

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02021 requires that the death certificate be executed within 24 hours after death sly filled in by the funeral son popers. Pages I and within 72 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o COUNTY b. COUNTY Carroll Maryland Frederick MARYLAND b. CITY OR TOWN (If autside carparate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) write RURAL and give nearest town) Rural--Sykesville 8mo. lidavs Brunswick d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS NO T Springfield State Hospital 503 Sixth Avenue 3. NAME OF Middle DATE remove carbon Day Year DECEASED (Type or print) 19 67 Delena Pear] DEATH Ambrose IF UNDER 24 HRS. S. SEX 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthday) Months Days Haurs white 1/15/85 female WIDOWED DIVORCED 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or fareign country) ase during most of working life, even if retired) **COUNTRY?** INDESTRY West Virginia USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Samuel Bohrer Eliza Hoyle 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dotes of service Springfield Hospital records, Sykesville, Md. 214-54-0537 cremation. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the buriol-transit p PART I DEATH WAS CAUSED BY ONSET AND DEATH Septicemia IMMEDIATE CAUSE (a) physician DUE TO Canditions, if any, which gave decubitus ulcers days rise to immediate cause (a), DUE TO stating the underlying cause as the hos been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome associated with circulatory disturbance with psychotic reaction. NO IC TO FUNERAL DIRECTOR: After this certificate for 20g. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item IB.) OR CONTRIBUTING CAUSE OF DEATH 10 detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dd. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year Hour o.m. factory, street, office bldg., etc.) Not While at work et work be retained by 2/27/ , 19 67, that (1/2 (we) last 21. I certify that *() (this haspital) attended the deceased fram-_, 1966__, to 2/27/ 1967, and that death accurred at 10:15%, from lauses and an the date stated above saw the deceased alive an. 220 SIGNATURE 22b. DATE SIGNED 2/27/67 DIRECTOR X" M.D. PHYS. PHYS 22d. ADDRESS Springfield State Hospital 22r PHYSICIAN'S director, po should be f NAME (Type) N. Buyukunsal, M. Sykesville. Maryland 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) (State) (County) RUNSWICK 2Sb. REGISTRAR'S SIGNATURE JUNERAL DIRECTOR 2Sq. REC'D BY REGISTRAR VR A15 (4) Minnelas

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Sykesville		2 years	Baltimore		311-11
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3. FATHER'S NAME			14. MOTHER'S MAIDEN NAME	100	
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18 CAUSE OF DEATH	(Enter only one couse or	y line for (a), (b), and (c).)	7	O HOODIOGI .	INTERVAL BETWEEN
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VR A15 (4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please ferrive carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to buriol, cremotian, or removal, and in any event, within 72 hours after death

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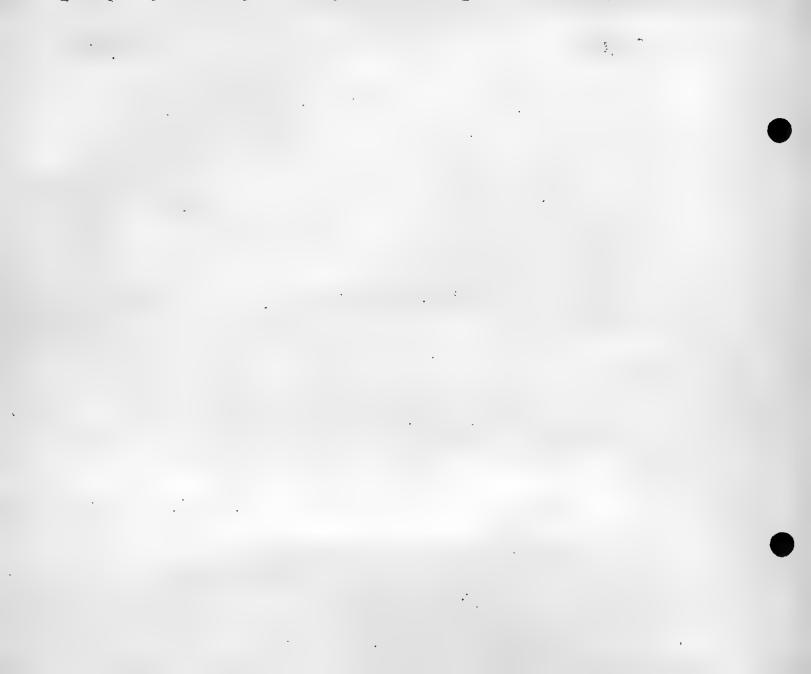
CERTIFICATE OF DEATH funeral should PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institutions a. COUNTY b. COUNTY Carroll MARYLAND Carroll 유유 b. CITY OR TOWN (if outside corporata limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL and give neerest town) vears Millers d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE hours at ON A FARM? 00 YES NO completely 3. NAME OF First Middle Lasi 4. DATE Month Day Year DECEASED (Type or print) DEATH carbon pa Samue 1 Feb. B. 19 67 Asper 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (In years | IF UNDER I YEAR) B. DATE OF BIRTH IF UNDER 24 HRS. S. SEX last birthday) and Months Days WIDOWEDY DIVORCED Male Jan. law requires that the death certificate physician 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11, BIRTHPLACE (County & State, or foreign country) 1 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even il ratirad) Farmer U.S.A. Carroll Co. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending Samue 1 J. Asper Brown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unknwn) | (If vas give war or dates of sarvica) Parkton. affending physician. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (al, (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gava sise to immediate cause DUE TO (a), stating the underlying PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY CERTIFICATION PERFORMED? 0 NO X 208. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CLCAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of itam 18.) this a (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or lown) (County) (Stata) Month, Day, Yaar factory, street, office bldg., etc.) While Not While Hour a.m. 19 p.m. 1964 to February 7., 1967, that (1) (we) last 21. | ceptify that (1) (this hospital) altended the deceased from J.B.M. 1.3. and that death occurred at \$4 M, from the causes and on the date stated above. 22b. DATE 22a. SIGNATURE ATTENDING STAFF SIGNED DIRECTOR PHYS. M.D director, page be filed with the death. Page 4 O FUNERAL 22d. ADDRESS 22c. PHYSICIAN'S NAME (TYPE 23d. LOCATION (City, 23a. BURIAL, CREMATION, 23b. DATE THEREOI NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Upperco. Buria St. Paul's 24 PUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE A15 Eline Funeral Home Hampstead, Md. DATE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

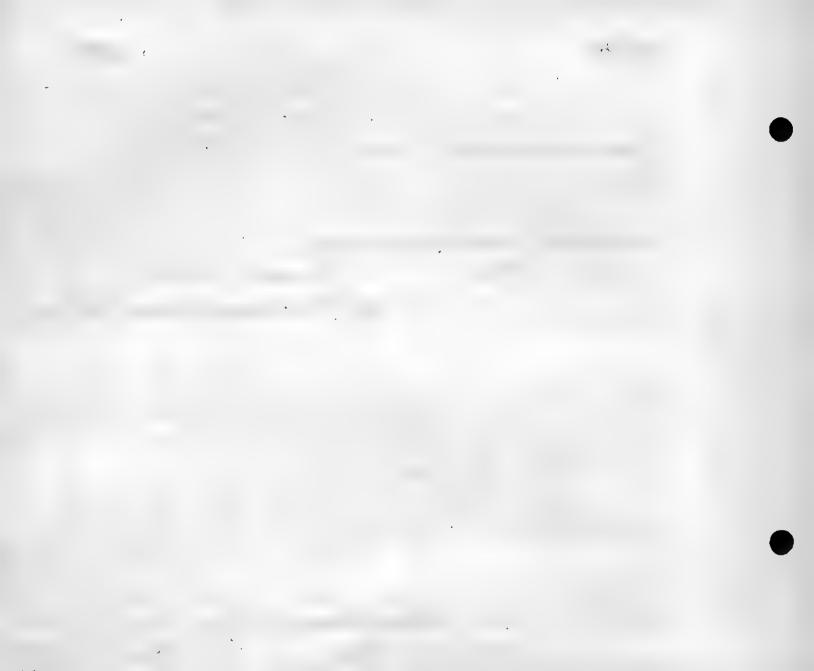
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY arrol after MARYLAND b. CITY-OR TOWN (if putside corporate limits. c. LENGTH OF STAY IN 1b TOWN (If outside corporate limits, write RURAL and give nearest town) within 72 hours write RURAL and give nearest town) 24 hours Ncheoli filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, IS RESIDENCE give street address) STREET ADDRESS ON A FARM? NO M YES etely and completely remove carbon in any event, with 3. NAME OF First Middle DATE Month Day Year 4. DECEASED DF DEATH (Type or print) 19 6 7 death certificate be executed 6. COLOR OR RACE 5. SEX 7. MARRIED D AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED last birthday) Months I Davs Hours WIDOWED DIVORCED 1Da. USUAL OCCUPATION (Give kind of work done | physician 9 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT (County & State, or foreign country) lease and ir during most of working life, even if retired) COUNTRY? Custodian ᆸ 13. FATHER'S NAME MUTHER'S MAIDEN NAME attending ph ermit. Then removal 15. WAS DECEASED EVER IN U.S. ARMED FORCES? ed by the attend transit permit. cremation, or r 16. SOCIAL SECURITY NO. 17. INFORMAN loomsbury Care (Yes, no, or unkown) (If yes give war or dates of service) NO INTERVAL BETWEEN CAUSE DF DEATH [Enter only one cause per line that the been signed by the burial-transit or to burial, crema ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. 2-20-67 IMMEDIATE CAUSE (a) gned DUE TO The law requires Cenditions, If any, which (b) gave rise to Immediate DUE TO cause (a), stating prior underlying cause last. (c) 98 CERTIFICATION WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health certificate the hospital or YES NO D PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CLAUSE OF DEATH DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part I or Part II of Item 18.) 4 detached Dept. (IF EITHER, NOTIFY MEDICAL EXAMINER) EAL 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm,) 20f. (City or town) (County) (State) be de State factory, street, office bldg., etc.) Hour a.m. MEDI While Not While p.m. at work at work retained 0 21. Jestify that (1) (this hospital) attended the deceased from JAN 31-1967 to 766 25 1967 that (1) (we) last EUTOR: shoul and that death occurred at 7 P. M. from the causes and on the date stated above. saw the deceased alive on DATE SIGNED 22a. SIGNATURE 22b. pe S page ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. Page 4 may ! M.D. PHYSICIAN'S NAME (Type) FUNERAL 22d. ADDRESS director, p should be 1 LOCATION (City, town or county) BURIAL, CREMATION: DATE THEREOF NAME OF CEMETERY OR CREMATORY (State) 23b. 23d 2 REMOVAL (Specify) Adow Rid Id FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) DATE 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH funeral and 2 and 2 death. hours after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE b. COUNTY OLL 0 MARYLAND by the Pages b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) I ENGTH OF STAY IN 16 TOWN Affoutside corporate limits, write RURAL and give nearest town) 1857 .= bon papers. within 72 hc d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address; e. IS RESIDENCE filled d. STREET ADDRESS ON A FARM? 24 NO P YES completely f we carbon pa event, withir within NAME DE Middle DATE Month Day 3. First Last 4. DECEASED JOHN WILLIAM DEATH 19 6 (Type or print) executed AGE (in years | IFUNDER 1 YEAR | IF UNDER 24 HRS and con remove 5. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months | Days Hours WIDOWED A DIVORCED 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KIND OF BUSINESS OR BIRTHPLACE (County & State, or fereign country) 10b. COUNTRY? death certificate be INDUSTRY MOTHER'S MAIDEN NAME removal LOCKA 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT d by the attend transit permit. cremation, or r 16. SOCIAL SECURITY NO. 17. (Yes, no, or unkown) | (If yes give war or dates of service) CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH igned by PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) attending physician. been signed the burial-trior to burial, DUE TO Cenditions, If any, which (b) gave rise to Immediate DUE TO (a), stating the underlying cause last. has PHYSICIAN: The law 88 WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health PERFORMED? certificate NO YES 208. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) detached for this (State) (County) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work p.m. 19 D O 1953 \mathbf{Z} that (\mathbf{J}) (we) last 21. I certify that (1) (this hospital) attended the deceased from DIRECTOR: .M. from the causes and on the date stated above. saw the deceased alive on and that death occurred at. 3 sho 22b. DATE SIGNED SIGNATURE 22a. MED. **STAFF** filed PHYS. DIRECTOR PHYS M.D. Da 112 **10 HOSPITAL** ADDRESS 22d. FUNERAL PHYSICIAN' TO FUNERAL director, p 22c. NAME (Type) 23d. LOCATION (City, town or county) (State) BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) REGISTRAR'S SIGNATURE 25Ь. **ADDRESS** FUNERAL DIRECTOR VR A15 (4) 20M



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death signed by the ottending physician and completely filled in by the funeral buriol-transit permit. Then please remove carbon papers. Pages I and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o COUNTY, **b** COUNTY MARYLAND c LENGTH OF STAY IN 16 (If autside carparate limits, c CITY OR TOWN (If autside carpetote limits, write RURAL and give nearest tawn) oon papers. Pag within 72 hours d NAME OF HOSPITAL OR INSTITUT ON (IF not in Hospital, give street address) d. STREET ADDRESS e IS RESIDENC ON A FARM? YES NO Z NAME OF DATE DECEASED EAR OF MONROK event DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 9. AGE (In years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH birthday) Months Days Hours WIDOWED 10o USUAŁ OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even firstired) INDUSTRY SERVICE MAN DILBURNEPS GAIR CONDITONEDS 14. MOTHER S MAIDEN NAME B. MARTIN 17. INFORMANT 16. SOCIAL SECURITY NO. Address (If yes give war ar dates at service cremation, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY: INANI IMMEDIATE CAUSE (o DUE TO CARCINIMA, ABDOMEN Conditions, if any, which gove rise to immediate cause (o), DUE TO stating the underlying couse the has been last PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? NOME NO O FUNERAL DIRECTOR: After this certificate 20g ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item, 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year 20e PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) Hour a.m factory, street, office bldg., etc.) 2-22-1967, that (1) (we) last 21. 1 certify that (1) (this hospital) attended the deceased from 2 -10 -1966 be retoined should saw the deceased olive an 2 -2- 1967, and that death occurred at 410 AM, from causes and on the date stoted above director, poge 3 sho should be filed with 22b. DATE SIGNED 22a. SIGNATURE ATTENDING M.D. PHYS 22c. PHYSICIAN'S NAME OF CEMETERY OR CREMATORY *LOCATION (City or Town) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify) 250. REC'D DE REGISTRAR 24 SUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/665 DATE







DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased bived, If institution, Residence before admission) b. COUNTY Raltimore a. COUNTY Carroll Mary and MARYLAND b. CITY OR TOWN (if oulside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Write RURAL end give searest lown)
Hamostead hours Owings Mills d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Ritters Lane Black & Decker Mfg. Co. YES NO X 3. NAME OF DATE Year Middle Month DECEASED THOMAS ALVEY RE.A TR February (Type or print) DEATH 19 6. COLOR OR RACE 7, MARRIED NEVER MARRIED 9. AGE (in years | IF UNDER I YEAR) IF UNDER 24 HRS. 5. SEX B. DATE OF BIRTH last birthday) Months Hours Male WIDOWED | DIVORCED 10a USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY II BIRTHPLACE (County & State, or fore gin country) | 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Baltimore, Md. Black & Dreitsman 001 esimer 13. FATHER'S NAME THE CHOTHER'S MAIDEN NAME Aurelia M. Dickernhoff Jemes Blair 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17 INFORMANT (Yes, ng, or unkown) (If yas give war or dates of sarvical Mrs.Louise B.Bleir Owings 18. CAUSE OF DEATH [Enter only one cause persina for (a), (b), and (c), ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immadiate couse DUE TO (a), stating the underlying causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 118] 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO X 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of in ury in Part | or Part | of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WEDICAL 20c. TIME OF INJURY 20d, INJURY OCCURRED . 20e, PLACE OF INJURY (Homa, farm, ... 20f. (City or town) (County) Month, Day, Year factory, straet, office bldg., etc.) While Not While Hour s.m. at work D.M. 21. I certify that (I) (this haspital) attended the deceased from ... White ., and that death occurred at 154M, from the causes and on the date stated above. saw the deceased alive on Lucite 20 1961 224. SIGNATURE ATTENDING SIGNED DIRECTOR PHYS. Karlac ADDRESS FUNERAL 224 22c. PHYSICIAN'S NAME (Type) E . McW 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town or county) (Stata) 23a, BURIAL, CREMATION, 23b, DATE THEREO! REMOVAL (Specify) Thurmont, Maryland Blue Ridge Cemetery S E Runi ADDRESS 25a, REC'D BY REGISTRAR | 25b, REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) Owings Mills, Md. DATE

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02031 CERTIFICATE OF DEATH death requires that the death certificate be executed within 24 hours after death. the attending physician and campletely filled in by the funeral isit permit. Then please somewe carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY b. COUNTY Maryland Carroll (e carban papers. Pages 1 gvent, within 72 hours after MARYLAND b. CITY DR TOWN (If outside corporate I mits, c. LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town Sykesville 2 mo. 8 days Baltimore d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS 1663 Park Heights Ave. Springfield State Howsi al YES NO 🔯 3 NAME OF 4. DATE Doy Year DECEASED (Type or print) OF DEATH February 13 1957 WILLIAM THOMAS CARTER IF UNDER 1 YEAR | IF UNDER 24 HRS. S SEX 6 COLOR OR RACE DATE OF BIRTH 9. AGE (tn years 7. MARRIED NEVER MARRIED lost birthdoy) Dovs Hours 7-18-85 White Male WIDOWED and impagy DIVORCED 10o JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if refired)

Thau "eur COUNTRY? **INDUSTRY** Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mary Allen John Wesley Carter 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 12. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) 211-41-7833 Records, Springfield State Hospital INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) signed by the burial-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (6) Heart failure Weeks attending physician. DUE TO Arteriosclerotic heart disease Conditions, if ony, which gove vears rise to immediate couse (a), DUE TO stating the underlying couse has been last. 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART LO phrase. Chronic brain syndrome assoc. with wenile brain disease without YES X Page 4 may be retained by the haspital ar O FUNERAL DIRECTOR: After this certificate ā 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2De. PLACE OF INJURY (Home, form, (City or town) 2Dd INJURY OCCURRED (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. at work at work 21. I certify that (I) (this hospital) attended the deceased from 12-5-65 . 19 . 1957, that (I) (we) lost sow the deceosed alive on 2-13-67 19 and that death accurred at 323 SPM, from causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. **ATTENDING** 2-13-67 DIRECTOR director, page 3 M.D. 22d, ADDRESS 22c. PHYSICIAN'S NAME (Type) Jorge Gonzales. Springfi 11 State Hospit 1. Sykesville 23d LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, (Stote) REMOVAL (Specify) Burial Baltimore, Md. 2/17/67 New Cathedral 2Sb REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 Wm. Cook-Brooks Inc Baltimore, Md. 21202



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dine.	OK:		saw the deceas	ed alive on	2/21/	19 <u>67</u> , one	That	death occurred at	9:15 M	, from causes		e date state TesiGNED	d above.
A A E	3.54 dwir		DIFF Y	- B.		67.13.20	M.D	ATTENDING D	MED. DIRECTOR	STAFF PHYS.		21/67	
TAL	At DI Page		22c PHYSICIAN S NAME (Type)	Naci N.	Buyul	cunsal, M. D		22d. ADDRESS		field S			•
ospi 4 n	INER Index	23	RIBIAL CREMATION	23b DATE THEREO		23c. NAME OF CEMETER		REMATORY		ATION (City or To			State)
TO HOSPITAL	Signal Control	1	REMOVAL (Specify)		67	White Roc	K	Cemetery_	54	kesvill	e,	M_{\odot}	1
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	20 M 1/66		Harry W.	YULVET	A	MYKANILLE	11	a. DATE F	EB 24	1967	T	les Jus	S. C.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death, after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. CDUNTY papers. Pages 1 a b. COUNTY a. STATE Fra MARYLAND b. CITY OR TOWN (if outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH DF STAY IN 16 write RURAL and give nearest town) hours RUTA ukesvi d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE event, within 72 ON A FARM? ND X OA YES letely carbon NAME DE 3. First Middle Last 4. DATE Month Day Year DECEASED DF Cocker comple (Type or print) DEATH 196 5. SEX and cor 6. COLOR OR RACE AGE (In years | IF UNDER 1 YEAR FUNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) | Months | апу Hours WIDOWED K DIVORCED = 1Da. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR (County & State, or foreign country) 12. CITIZEN OF WHAT 99 during most of working life, even if retired) INDUSTRY COUNTRY? FARMI rmek certificate transit permit. Then of the creation, or removal FATHER'S NAME MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. | 17. INFORMANT Address death (Yes, no, or unknwn) \ (If yes give war or dates of service) Sykesvil 18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), ONSET AND DEATH PHYSICIAN: The law requires that the been signed or the burial-transit ior to burial, cremi PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a attending physician. Conditions, If any, which to Immediate DUE TO stating prior underlying cause last. has 35 (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CO RIBUTING TO DEATH BUT NOT RELAXED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. S AUTOPSY for use Health r this certificate h detached for use te Dept. of Health PERFORMED! the hospital or YES ND 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY DCCURRED, (Enter nature of Injury in Part 1 or Part 1) of Item 18.) DR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dd, INJURY OCCURRED 20e. PLACE DF INJURY (Home, farm, (State) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) should be derith the Str factory, street, office bldg., etc.) Hour a.m. Not While at work While 19 at work retained 21. I certify that (I) (this hospital) attended—the deceased from that (i) (we) last DIRECTOR: age 3 should led with the and that death occurred at 2.04th from the causes and on the date stated above. saw the deceased alive 22a. SIGNATURE DATE SIGNED De de page : ATTEN DING MED. STAFF DIRECTOR M.D. PHYS. PHYS PHYSICTAN'S FUNERAL 22c. 22d. ADDRESS director, p NAME (Type) 23b. NAME OF CEMETERY OR CREMAPORY LOCATION (gity, town or county) (State) 23a. BURIAL, CREMATION DATE THERED! 23d. REMOVAL/(Specify) 0 X **FUNERAL DIRECTOR** REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR AJ5 (4) 20M 1/65

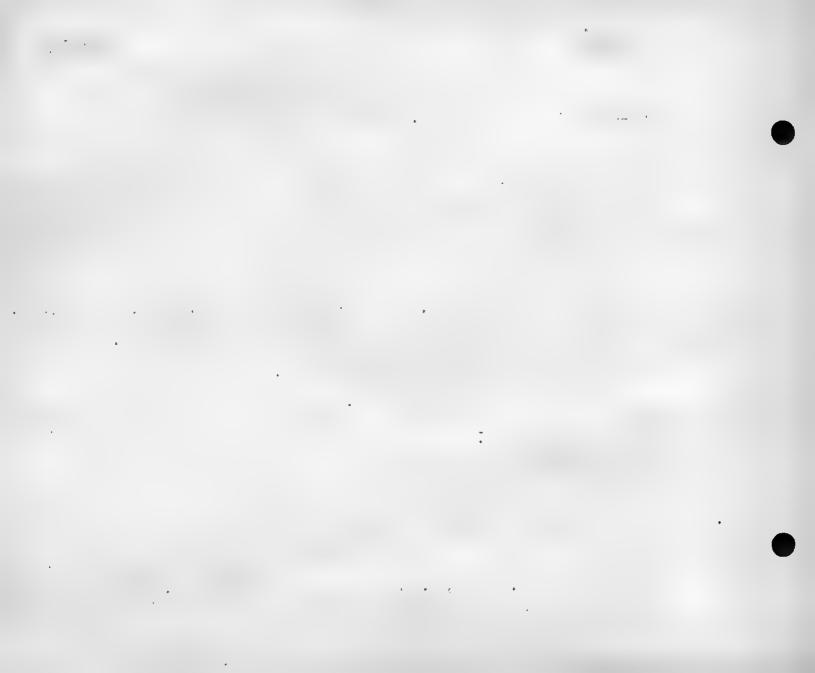


	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE	1, MARYLAND
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be executed 7.11 24 hours after nd completely to by the funeral should within 72 hours after death.	1. PLACE OF DEATH e. COUNTY D. CITY OR TOWN (if outside corporate limits, write RURA) b. CITY OR TOWN (if outside corporate limits, write RURA) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) J. NAME OF DECEASED [Type or print] T. DATE Month OF DEATH 9. AGE (In years If UN Month OF J. DATE	AL end give neerest town) O. IS RESIDENCE ON A FARM? YES NO. Day Year 12 1967 IDER 1 YEAR IF UNDER 24 HRS.
te law requires that the death certificate E anding physician. been signed by the attending physician an rial-transit permit. Then please remove car cremation, or removal, and in any event,	10a. USUAL OCCUPATION (Give kind of work done during most of working, life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 117. BIRTHPLACE (County & State, or fossion country) 12. WAS DECOMOSED EVER IN U.S. ARMED FORCEST 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECOMOSED EVER IN U.S. ARMED FORCEST 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown), (Ifyesgive were redetes of service) 222-34-5108 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which gove rise to immediate cause DUE TO Conditions, if eny, which gove rise to immediate cause	D. CITIZEN OF WHAT COUNTRY? A. A. BULL INTÉRVAL BÈTWEEN ONSET AND DEATH
TAL OR ATTENDING PHYSICIAN: The second of the hospital or after the certificate has a SAL CTOR: After this certificate has a set of the but age 3 should be detached for use as the but in the State Dept. of Health prior to buriate.	Ceuse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBLING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part 1 or Pert II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20a. TIME OF INJURY Month, Day, Year Hour e.m. 19 While et work et work	(County) (State)
TO HOSPI death. Paged of the Page of the P	230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION ICITY, LOWING REMOVAL ISDOCION 2/14/67 ENOUGH MUNICIPAL DIRECTOR'S SIGNATURE ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRA 25c. PEB 14 1967	my md.





Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02036 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 havrs after death signed by the attending physician and campletely filled in by the funeral burial-transit nermit. Then please remaye carban papers. Pages 1 and burial, cremation, ar remayal, and the any event, within 72 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY a STATE **b.** COUNTY Carroll MARYLAND Maryland b CITY OR TOWN (If outside carporate limits, write RURA, and give negres) town)
Rural—Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) 3m. 2hdavs Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Springfield State Hospital 6205 Eunice Avenue YES NO DE 3 NAME OF Middle 4. DATE Lost Manth Year DECEASED
(Type or print) Mildred Eliza Debelius 19 67 DEATH S SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 7. MARRIED **NEVER MARRIED** 8/1 birthday) Manths Doys Hours female white 3/23/82 WIDOWED DIVORCED 1Do USJAL OCCUPATION (Give kind of work done during most of working life, even if refired) 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? INDUSTRY Maryland USA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Charles Hall Henrietta Mullin 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) [If yes give wor or dotes of service] unk. Springfield Hospital records, Sykesville, Md. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY Septicemia and acute meningitis (organism unkn.) IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Canditians, if any, which gove Infected decubitus ulcers. weeks rise to immediate cause (a). DUE TO stoting the underlying couse as the prior tal Bronchopneumonia. davs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
Chronic brain syndrome associated with senile brain disease with
psychotic reaction. WAS AUTOPSY PERFORMED? ed for use of Health p YES T NO 20g. ACCIDENT WAS UNDERLYING [1] 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd. INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (City or tawn) (County) (State) 20r TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) 21 | certify that (this haspital) attended the deceased fram. 10/27/_ , 1966__ , ta__ 2/21/, 1967, that \$1) (we) last 2/21/ 1967, and that death accurred at 2:00 aM, fram causes and an the date stated above. saw the deceased alive an 22a SIGNATURE 22b. DATE SIGNED **ATTENDING** 2/21/67 leen M.D. director, page should be filed Springfield State Hospital 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Edmee J. Reeves, M. D. Sykasyille Manyland 23c. NAME OF CEMETERY (State) BURIAL, CREMATION 25b. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR Minula Judge FFR



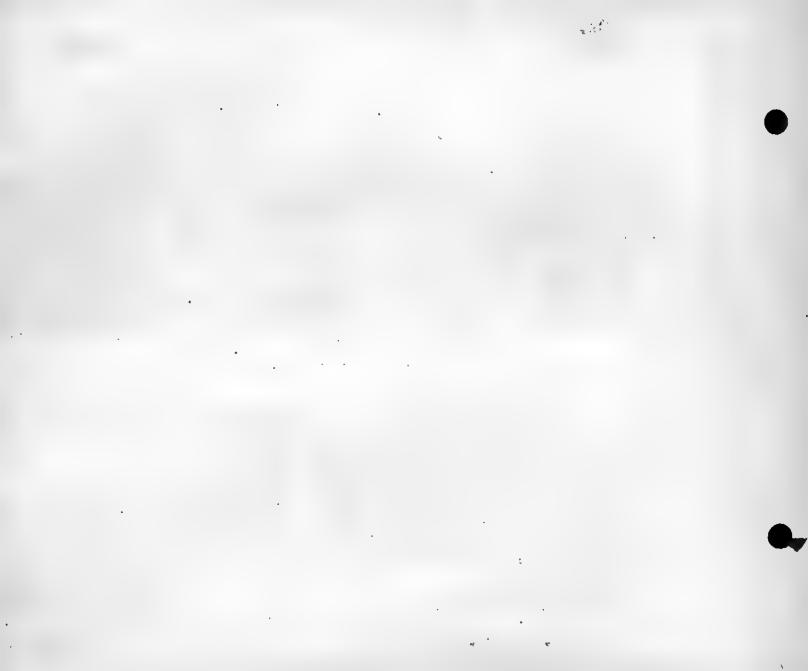
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within within	3.	NAME OF FIRST	t	Middle	ll Oy	1/7777/1	DATE	Month	Day	YES NO X
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	15. (Ye	WAS DECEASED EVER IN U.S. ARMED FOR t, no, or unknown) (If yes give war or dates of s	CES? 16.	- M	INFORMANT NAE PU	llen	- Suk	Address	le M	d.
	1	18. CAUSE DF DEATH [Enter only one			<i></i>		+		INTE	RVAL BETWEEN
burial, cremation, or		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a	Arter	riosclerotic h	neart d	isease,	Cardia	failu	re,	
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d	FICAT								YE	S NO
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	MEDICAL	20c. TIME OF INJURY Month, Day, Yo Hour a.m. p.m. 19	ear 20d. II While at work	Mot While my fact	ACE OF INJUR ory, street, of	(Y (Home, farm, fice bldg., etc.)	20f. (City o	r town)	(County)	(State)
		21. I certify that (I) (this hospi		d the deceased from_	196					nat (I) (we) las
		saw the deceased afive on Fo	eb. 15	19 67, and tha	nt death DCC	urred at 1 P	M, from the	causes and	on the dat	e stated above
		Howars	23	Hall M.	D. PHYS.	ING MED.	CTOR PH	AFF IYS.	Feb. 1	5, 1967
1		22c. PHYSICIAN'S NAME (Type) Howard E	Hall	. M.D.	22d. A	DDRESS Sykesy	rille, N	Marylan	d	
í	23a	BURIAL, CREMATION, 23b. DATE THE	IEREOF	23c. NAME OF CEMETER	8	TORY 2	23d. LOCATIO		or county)	(State)
1	24	SULLA 12-18-	6/	ADDRESS	cemen	ERY 25al REC'D E	SY REGISTRAR	25b. REGJS	STRAR'S SIGN	ATURE
P		Harry W. Haigh		Sykicult	Md.	DATE	2 0 196	file	carles	usar
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MARYLAND STATE DEPARTMENT OF HEALTH



1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
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after deat	ges and safter deat	1.	PLACE OF DEATH B. COUNTY COUNTY MARYLANO C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b	a, STATE MARY	LAND	b. COUNTY	: Residence before admission) ARDLL (AL and give nearest town)
n 24 hours	completely lined in by the carbon papers. Page event, within 72 hours a	E	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address 28 WEBSTER ST.	d. STREET ADDRESS 28 WE		R ST.	e. IS RESIDENCE ON A FARM? YES NO
executed within	event, wil	5.	NAME OF First Middle OFCEASED (Type or print) WILLIAM FRANCIS SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIEO	DOYLE 8. OATE OF BIRTH	4. DATE DF DEATH	Month FEB. AGE (In years IFUND Month	Day Year 2 3 1967 ER 1 YEAR IF UNDER 24 HRS Hours Min.
exec	physician and in please remo	10a	USUAL DECUPATION (Give kind of work done in most of working life, even if retired) The following life is a working life in the life in th	MAY 5 187 11. BIRTHPLACE (I	County & State, o	Z yrs.	CITIZEN DE WHAT COUNTRY?
E E	The The	13,	FATHER'S NAME MATTHEW DOYLE WAS DECEASED EVER INU.S. ARMED FORCES? 16. SDCIAL SECURITYNO. 17.	14. MDTHER'S MAI £217AL		DONNEL Address CA	
leath	on, or	(Ye	no, or unkown) ((f yes give war or dates of service)	IRS WILLIA	MF-D		ADDRESS
res that the physician.	oeen signed by the atten the burial-transit permit. or to burial, cremation, or		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), apd (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TD Conditions, If any, which (b)	ular Ren	el De	Slave (Genel)	INTERVAL SETWEEN ONSET AND DEATH SOUCHARY
aw tten	as as	CATION	gave rise to immediate cause (a), stating the out to underlying cause last. (c) PARTIL DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RE	LATED TO THE TERMINAL	. DISEASE COND	ITION GIVEN IN PART 1	(a) 19. WAS AUTOPSY PERFORMED? YES NO NO
	this certificate detached for use te Dept. of Health	L CERTIFICATION	20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				18.)
oy the	<u> </u>	MEDICAL	p.m. 19 at work at work	tory, street, office bldg.,	farm, 20f. (c) etc.)	ity or town) (County) (State)
TO HOSPITAL OR ATTENDI	J FUNERAL DIRECTORS AT director, page 3 should be should be filed with the S		22a. SJGNATURO				o the date stated above. OATE SIGNED
= ;	2	23a	BURIAL, CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETER REMOVAL (Specify) 2/27/67 WESTMINSTE ADDRESS	ER CEMETER 25a. RI	PC'D BY REGIS	100	-0 4.5
VR ≱ 20M	1/65	A	2/mjers p; Wolmmen, Ma:	DATE	EB 28	1967 Jan	new Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fired, if institution: Residence before admission) a. COUNTY a. STATE h. COUNTY by the financial Pages 1 Carroll Carroll hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) and completely filled in by emove carbon papers. Pag any event, within 72 hours Hampstead Hamostead d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 334 Main Street 334 Main Street NO X YES executed within NAME DE First Middle Month Day Last DECFASED Blanche J. Eburg February 67 (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS DATE OF BIRTH 7. MARRIED NEVER MARRIED 9. last birthday) | Months | Days Hours Female White WIDOWED DIVORCED [Jan. 31. 1902 stcian a please re , and in a 10a, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT þe CDUNTRY? West Virginia ÙSA Housewife certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME been signed by the attending of the burial-transit permit. There or or to burial, cremation, or removal. Lula Belle Smith John W. Frush 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address death (Yes, no, or unkown) (If yes give war or dates of service) Charles E. Eburg Hampstead. 18. CAUSE OF DEATH [Enter only one cause per, line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the ifter this certificate has be be detached for use as th State Dept. of Health prior underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES NO 2Da, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While retained by FIENDING at work at work the 21. I certify that (I) (this hospital) attended the deceased from A director, page 3 should should be filed with the and that death occurred at # M. from the causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE ATTENDING M.D. PHYS. DIRECTOR PHYS. Page 4 may PHYSICIAN'S 22d. ADDRESS NAME (Type) M.C.Porter Tield Hampstead, Md. 23a. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) Hampstead Cemetery Hampstead, Md. Burial 258. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS Tipton-Eline Funeral Home Hampstead. Md. VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02041 CERTIFICATE OF DEATH certificate be executed within 24 haurs after death signed by the attending providing and completely filled in by the funeral hirial-transit permit. These-please remave carbon papers. Pages I and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o...COUNTY b. COUNTY LANNO 11 MARYLAND c CITY OR TOWN (If gutside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If autside carporote limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 lease remave carban papers. Pacand in any event, within 72 haurs Wist MINST d, NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS B IS RESIDENCE ON A FARM? HOS A YES NO Z NAME OF Middle 4. DATE Day Lost Year DECEASED ONMAM ELB 196 DEATH S SEX 6 COLOR OR RACE DATE OF BIRTH AGE (In years 7 MARRIED birthdoy) Months Hours Dovs WIDOWED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) INDUSTRY LONTractor 13. FATHER S NAME crematian, ar remava NHY 17. INFORMANT 16. SOCIAL SECURITY NO requires that the death (Yes, no, or unknown) ((If yes give wor or dates of service 1B CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART | DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o). DUE TO Conditions, if only, which gove nse to immediate cause (a), DUE TO stating the underlying cause Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been use as the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) NO ō 20o. ACCIDENT WAS UNDERLYING [1] 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) (Stote) Hour o.m. Not While factory, street, office bldg . etc.) at work . 19 6 7 that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram_ -7 - 12, 1966, ta 19.6.7, and that death accurred at \(\frac{130P}{30P} \) M, fram causes and an the date stated above. saw the deceased alive an 22b DATE SIGNED 22o. SIGNATURE ATTENDING M.D. DIRECTOR PHYS. 22d ADDRESS AJONCHERE MID NAME (Type) /2 directar, shauld 23c MAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION. (State) MOVAL (Specify) Larys Cemilon 24 FUNERAL DIRECTOR 250 REC'D' BY REGISTRAR 25b REGISTRAR S SIGNATURE VR A15 (III) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND FOR STATE CERTIFICATE OF DEATH MEDICAL EXAMINER'S **HEALTH DEPT** PLACE OF DEATH USWAL-RESIDERCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY b. COUNTY a. STATE Carroll Maryland Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND the funeral 鲁 Department after death b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b (Rural) Sykesville 30vr. 4mo. Sykesville, Maryland . e. IS RESIDENCE ON A FARM? ш d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS lay 3 to t Page State Springfield State Hospital YES T NO 3 any dela 2, and NAME OF First Middle Last 4. DATE Month Day Year EXAMINER: This certificate should be executed within 24 hours after death. If any d certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, an nould be forwarded to the Chief Medical Examiner's Office along with form PM3. DECEASED John Harrison Eldridge DEATH 1967 (Type or print) 2 with 5. SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR) F UNDER 24 HRS. 6. COLOR DR RACE NEVER MARRIED 3 7. MARRIED last birthday) Months I **Oays** Hours M 2-27-II 1910 56 WIDOWED OIVORGED [l and event 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) INDUSTRY Laborer Tennessee USA 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME John H. Eldridge Gladys Wilson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT Address 16. SOCIAL SECURITY NO. permit. F (Yes, no, or unknwn) I (If yes give war or dates of service) no none Hospital Records INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: burial-transit cremation, or Bi-lateral Lobar Pneumonia - IMMEDIATE CAUSE (a cremation, DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the 63 underlying cause last used as to burial, PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY CERTIFICATION PERFORMED? Schizophrenic reaction, paranoid type YES X NO F 20a. EXTERNAL CAUSE WAS PRIMARY [] or CONTRIBUTING [] CAUSE OF DEATH. 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 1) of Item 18.) pe o 교등 shoul 3 shou agent, 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) MEDICAL 20c. TIME OF INJURY Month, Day, Year Hour a.m. Not While While CTOR: Page designated at work L at work and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy Inquiry Inspection the cert es. RECTOR: Undetermined manner Wateral causes Suicide Homicide death resulted from: Accident CHIEF MEOICAL EXAMINER YOUR Page execute ASSISTANT MEDICAL EXAMINER 5 SIGNATURE 20 for DEPUTY MEDICAL EXAMINER X FUNERAL Health **EXAMINER'S** Glenn Speicher retained NAME (Type) LOCATION (City, town or county) NAME OF CEMETERY OR CREMATORY rec BURIAL, CREMATION. 23c. REMDVAL (Specify) 0 10 MA-hor REGISTRAR'S SIGNATURE REC'D BY 25a. UNERAL DIRECTOR VR A15ME 3500 4-64



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02043 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death death 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) the attending physicion and completely filled in by the funeral sit permit. Then please remove carbon papers. Poges 1 and mation, or removal, ond in on<u>y eyent, within 72 hours after dea</u> 1. PLACE OF DEATH a. COUNTY Carroll a. SMaryland b. COUNTY Washington MARYLAND CITY OR TOWN (If autside carparate limits, write RURA, and give nearest tawn) CLENGTH OF STAY IN 16 c CITY OR TOWN (If gutside corporate limits, write RURAL and give nearest town) Hagerstown Lyr.8mos.22dys Sykesville d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in haspital give street address) e IS RESIDENCE ON A FARM? 1059 Florida Ave. NO TY Springfield State Hospital 4. DATE 3 NAME OF Middle Year Last DECEASED (Type or print) OF DEATH WALTER ENSOR 67 FEBRUARY FRANKLIN 19 in ony event, 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED 59 ast birthday) Months Hours Days White 9-2-07 Male WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10a USUAL OCCUPATION (Give kind of work done 1), BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during mast af working life, even if retired) COUNTRY? INDUSTRY Maryland
14 MOTHER'S MAIDEN NAME None 13. FATHER S NAME cremation, or removal. Howard Ensor Alva B. Fogle 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, ar unknawn) (If yes give war ar dates af service) Records, Springfield State Hospital Noné 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) NTERVAL BETWEEN signed by the burial-tronsit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Cardiac arrest IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave Hours (b) Acute myocardial infarction rise to immediate cause (a), DUE TO stating the underlying cause os the fast. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, chronic undifferentiated type 19 WAS AUTOPSY PERFORMED? NO X YES: ρ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF FITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (State) TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, affice bldg., etc.) Nat White at work 21. I certify that (I) (this haspitot) attended the deceased from 5-28-65 saw the deceased glive on 2-20-67 to and that death according and that death accurred at 2-20-67, 19 that (I) (we) last M; fram causes and an the date stated above. saw the deceased alive an-22b. DATE SIGNED 22a, SIGNATURE ATTENDING 2-21-67 X M.D. DIRECTOR PHYS Springfield State Hospital 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz. Sykasville, Maryland director, should 23c NAME OF CEMETERY OR CREMATORY (State) 23b DATE THEREO! (Caunty) 23a BURIAL, CREMATION, REMOVAL (Specify) VR A15 (4) 20 M 1/66



DIVISION OF STATISTICAL RESEA		IEALTH TREET, BALTIMORE 1, MARYLAND
02044	CERTIFICATE OF DEATH	02039
1. PLACE OF DEATH • COUNTY	2. USUAL RESIDENCE (W	here deceased lived, It institution: Residence before edmission
b. CITY OR TOWN (if ourside corporate limits,	c. LENGTH OF STAY IN 16 c. CITY OR TOWN (H out.	to corporate limits, write RURAL and give necress lown)
ite RURAL and give fleagest lown)	6 Watne	motie
d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp	oital, give street address) d. STREET ADDRESS	ned on a farm.
NAME OF DECEASED	Middle Last 4. D	ATE Month Day Year
(Type or print) LE MOY OL SEX [6. COLOR OR RACE 7, MARRIED	LIVER FARVER	EATH FEB 1967
male Whit, WIDOWED	DI DIVORCED 771.ADAL 30 18	GO (yrs. Months Days Hours Min.
tos. USUAL OCCUPATION (Give kind of work tob. KIP done dur no mast of working life, even if retired)	NO OF BUSINESS OR INDUSTRY, 11. B RTHPLACE (COMINY & ST	ate, or loreign country) 12. CITIZEN OF WHAT COUNTR
13. FATHER'S NAME	LA SUPPLICATION CANALLY	ma. 4.3.4.
15. WAS DECEASED EVEN U.S. ARMED FORCEST , 16. S	SOCIAL SECURITY NO. 1 17. INFORMANT	Hames
(Yes, no, or unkown) (Ilyes give were redetes of service)	20-26-7436 Mrs. Loik - 0	Allren address
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY,	ne for (a), (b), end (c).]	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (e)	commy orecurs	24 hre
Conditions, if eny, which by [b]		_
(a), stelling the underlying DJE TO cause last.		
	TRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DI	SEASE CONDITION GIVEN & PART I(e) 19. WAS AUTOPS PERFORMED?
PART II OTHER SIGNIFICANT CONDITIONS CONT CONTRIBUTION 200. ACCIDENT WAS UNDERLYING 200. DEATH III ETHER. NOTIFY MEDICAL EXAMINER;	CREETOW IN. URY OCCURED. (Enter noture of injury in Port I o	Part ol stem 18.}
Hour e.m. While	Not While lectory, street, office bldg., etc.)	f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attend	led the deceased from 2/4 , 1963	,
saw the deceased alive on27.1.3	19.67., and that death occured at SOM,	from the causes and on the date stated about 22b. DATE
Julius Chapt	M D. ATTENDING MED.	STAFFSIGN
NAME (Type) Jalius Che	p ko 228. ADDRESS The	- St. Westminster, Md.
238. BURIAL, CREMATION 236. DATE THEREOF.	23c. NAME OF CEMETERY OR CREMATORY 23d	LOCATION (City, lown or county) (State)
British 2/16/67	APORESS PECO BY	REGISTRAR 256, REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. death. 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) PLACE OF DEATH a. COUNTY 1. a. STATE **b. COUNTY** bon papers. Pages 1. within 72 hours after after the MARYLAND b. CITY OR TOWN (if outside corporate limits. (Moutside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN Ŕ write RURAL and give nearest town) 24 hours .= d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS filled ON A FARM? YES PO NO completely 1 executed within 3. NAME DE First Last 4. DATE Month Day Middle **DECEASEO** event, (Type or print) DEATH 196 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months I Days Hours | Min. and con 5. SEX 6. COLOR OR RACE DATE OF BIRTH 9. 7. MARRIED NEVER MARRIED any WIDOWED #5 DIVORCED attending physician a sernit. Then please re on, or removal, and in 12. CITIZEN OF WHAT .= 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR (County & State, or foreign country) death certificate be during most of working life, even if retired) INDUSTRY MOTHER'S MAIDEN NAME FATHER'S NAME G. STANS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unkown) \((If yes give war or dates of service) MRSI ed by the atte transit permit cremation, ou AIRY CAUSE OF DEATH [Enter only one cause per-line for (a) INTERVAL BETWEEN requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) been sight the burial-tra DUE TO Conditions, If any, which gave rise to immediate **DUE TO** (a), stating the prior underlying cause last. 33 CERTIFICATION 119. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health PERFORMED? certificate YES NO 🔽 PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW NJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detached MEDICAL 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, (County) (State) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town factory, street_office bldg., etc.) Hour a.m. While Not While After Id be d p.m. at work at work retained hould h the 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should lied with the M, from the causes and on the date stated above. saw the deceased alive on and that death occurred at 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. STAFF PHYS. page DIRECTOR TO HOSPITAL (Page 4 may PHYSICIAN'S 22d. ADDRESS FUNERAL 22C. director, p should be 1 NAME (Type) BURIAL, CREMATION, DATE THEREOF 23d. LOCATION (City, town or county) (State) 23b. 23c. NAME OF 23a. PENOVAL (Specify) 2 FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 29b. REGISTRAR'S VR A15 (4) DATE 20M 1/65

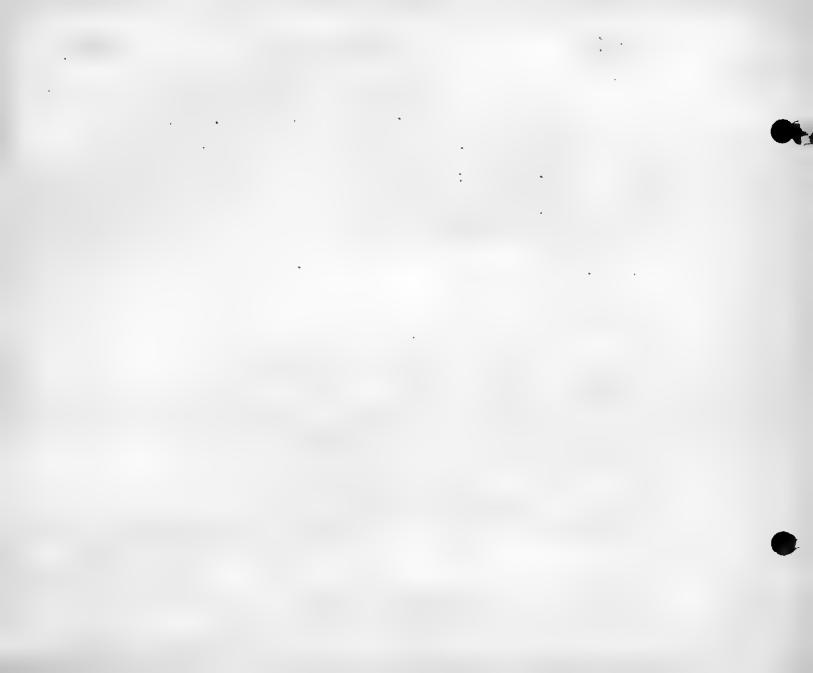


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02046 requires that the death certificate be executed within 24 haurs after death by the funeral death 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) 1. PLACE OF DEATH a. STATE, a. COUNTY **b.** COUNTY Carroll Carroll Harvland MARYLAND c CITY OR TOWN (If guitside carparate limits, write RURAL and give nearest town) b City OR TOWN (If outside carparate limits, write RURAL and give nearest town) **ELENGTH OF STAY IN 36** 2 Months Sykesville Rural Westminster filled in I e IS RESIDENCE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ON A FARM? Corroll Gel. Hospital YES 🔁 NO 🗀 NAME OF First Middle Last 4. DATE Manth Day Year DECEASED 1967 (Type or print) Horatio Stanley DEATH Feb. S SEX 9. AGE (In years last birthday) IF UNDER 1'YEAR IF UNDER 24 HRS. 6 COLOR OR RACE 8 DATE OF BIRTH 7. MARRIED **NEVER MARRIED** remave o ony eve Months Days Hours WIDOWED DIVORCED 2-15-1399 [a] e 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) physician o Jeo please/ during mast of working life, even if retired) COUNTRY? INDUSTRY and Ohio Building Building 14. MOTHER'S MAIDEN NAME 13 FATHER S NAME ar removal, Sarah Banas Harry Fox attending permit. The 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (Yes, na, ar unknown) (If yes give war or dates of service) signed by the atter burial-transit permit burial, cremation, a Szicesvill INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate cause (a). DUE TO ed tar use as the t caf Heolth prior tat stating the underlying cause has been last. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO O FUNERAL DIRECTOR: After this certificate 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Haur a.m. factory, street, affice bldg., etc.) Not While While at wark at wark 21. I certify that (1) (this haspital) attended the deceased from Dic 26, 1966, to Feb 27, 1967, that (1) (we) last be retained director, page 3 should should be filed with the saw the deceased glive an Feb 27 1967, and that death accurred at 937M, fram causes and an the date stated above. 22b. DATE SIGNED 22o, SIGNATURE ATTENDING STAFF PHYS. M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) S. HARSHEY M.D & anchon de 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23g. BURIAL CREMATION. 23b. DATE THEREOF REMOVAL (Specify) Pleasant Couetors 250. REC D BY REGISTRAR 256. REGISTRANS SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 1967 DATE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) o. COUNTY b. COUNTY CARROLL MARYLAND CARROLL CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town) 78 KRS WESTMINSTER ESTMINSTER requires that the death certificote be executed within 24 hour d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? paper within CARROLL CO. GEN 245 W. MAIN NO P NAME OF pou Middle Lost 4 DATE Doy DECEASED ALBERTA 26 (Type or print) 0 event DEATH S. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** remove lost birthdoy) Doys JAN.17 1889 DIVORCED WIDOWED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? pleose NESTMINSTER CARROLL CO mme-13. FATHER'S NAME ELIZABETH R. WILLIAR WILLIAM H. GEIMAN IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (if yes give wor or dates of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN signed by the burial-tronsit PART I DEATH WAS CAUSED BY QNSET, AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to Immediate cause (a), DUE TO stoting the underlying couse the has been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO S-YES [certificate for 200 ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED (County) (State) factory, street, affice blda., etc.) Not While O FUNERAL DIRECTOR: After of wark 2). I certify that (I) (this haspital) attended the deceased fram from 25, 1967, ta 66, 1965 that (I) (we) last saw the deceased alive an from 26, 1967, and that death occurred at 23, M, fram causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) director, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL, CREMATION (County) (Stote) REMOVAL (Specify)

24. FLINERAL DIRECTOR 25g, REC D BY REGISTRAR VR A15 (4) FEB 28 DATE



1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	02048 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02043
HEALTH 'DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e funeral may be partment	Carroll MARYLAND D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
to the funeral to the funeral to 5 may be Department after death.	Sykesville Lyrs.8mos.4dys Baltimore d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
ay 13 to the Page Dage Dage Dage Dage	Springfield State Hospital 603 Wyeth St. ON A FARM?
delay la del	3 NAME OF First Middle Last 1.4 DATE Month Day Year
PM3.	OFFICE OF PRINT) OFFICE OF PRINT) DOROTHY DALTON GORTH DEATH FEBRUARY 23 19 67
ges 1, 2 form P	(Type or print) DOROTHY DALTON GORTH DEATH FEBRUARY 23 19 67 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH FEMBLE WILDOWED 7 DIVORCED 5-3-24 White WILDOWED 7 DIVORCED 5-3-24
e Page e Page with fo	Female White Widowed Divorced 1 2-2-24 42 yrs.
S wi	10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) U.S.A.
alon,	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
14 hour ltem of the file of and file	Frederick Gorth Edith Marney
n 24 in 1 s Off t. Fi	(Yes, no, or unknwn) (If yes give war or dates of service)
within ; pencil ir miner's permit. removal,	None Records, Springfield State Hospital 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
in p in p in p in p in p in p or re	PART I. DEATH WAS CAUSED BY: PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to occlusion of the entire bronchus Minutes to
"de executed "peding" in "pending" in Medical Exan is burial-transit i cremation, or i	DUE TO with recently ingested food an hour
be e pend Media urlal	Conditions, if any, which gave rise to immediate (b)
a b	cause (a), stating the DUE TO underlying cause last. (c)
EXAMINER: This certificate should be executed within 24 hours after death. If any delthe certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Tilles. Trifles. Trifles. Trifles. Gesignated agent, prior to burial, cremation, or removal, and trans event within 72 houdesignated agent, prior to burial, cremation, or removal, and trans event within 72 houdesignated agent, prior to burial.	Lab Urea ally and
to the	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PRIMARY OF CONTRIBUTING TO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) PRIMARY OF CONTRIBUTING TO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Became cyanosed & suddenly stopped breathing. The doctor
certify riting ded to ded to prior	PRIMARY OF CONTRIBUTING DECAME Cyanosed & suddenly stopped breathing. The doctor
R: This cer cate, writin forwarded 3 should b agent, pric	CAUSE OF DEATH. Was called, who gave emergency care, but to no avail. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (county) (State) Hour a.m. While Not while factory, street, office bidg., etc.) Springfield State Hospital
Cath	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm. 20f. (City of town) State Springfield State Hospital Sykesville Clark Circle Sykesville Carroll Maryland
Certification of the Page	21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and in my opinion
the cessign design	death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner .
EDICAL Urte th ge 4 your JIRECA its d	ACTUAL SIGNATURE (IN CLUME) ASSISTANT MEDICAL EXAMINER () 22. DATE SIGNED
TY MEDIC execute cascute Page 4 for you RRI DIREIT th or its	DEPUTY MEDICAL EXAMINER X
EPU ase ector aine UNE Heal	23a. BURIAL CREMATION I 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
Daggar Day	Busine 2/27/67 Toudon Back Com. Balto. Mid.
W. W.	24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR'S SIGNATURE COMPANY FEB 2 7 1967 CHARLES SIGNATURE
VR ALSME (5) 5M 1/65	John Je Cown Down Holling St. DATE LOS 1001

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 1. PLACE OF OEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) . COUNTY b. COUNTY MARYLAND Department after death. the funeral 5 may be c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) a. IS RESIDENCE delay 1 rd 3 to 1 Page ON A FARM? State hours ND X and 3. NAME OF First Middle Last DATE Month Year DECEASEO B. (Type or print) DEATH 2 with within IF UNDER 24 HRS 24 hours after death, If in Item 18. Give Pages 1, office along with form 5. SEX AGE (In years | IF UNDER 1 YEAR last birthdey) | Months | Hours 1 WIDOWED OLVORCEO and ? 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? EMPLOYEE CA HOTEL pages in any 13. FATHER'S NAME FICK Ele and and 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT (Yes. no. or unkewn) | (If yes give war or dates of service) permit. I removal, EXAMINER: This certificate should be executed within certificate, writing the word "pending" in pencil liquid be forwarded to the Chief Medical Examiner's 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), PART I. DEATH WAS CAUSED BY: burial-transit cremation, or IMMEDIATE CAUSE (a) cremation, DUE TO Conditions, if any, which (b) gava rise to immediata DUE TO cause (e), stating the 601 used as a to burial, underlying cause last. (C) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION YES ND X should be 20a. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) 3 shoul agent, MEDICAL (Stata) 20c. TIME OF INJURY Month, Oav, Year 20d. INJURY OCCURRED 120s. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc. Hour a.m. While Not Whila at work at work inspection 🔀 the cert 21. I certify that I took charge of the remains described above, held an Autopsy I Inquiry and in my opinion Undetermined manner death resulted from: / Natural causes Suicide Homicide Accident CHIEF MEDICAL EXAMINER your 22. DATE SIGNEO ASSISTANT MEDICAL EXAMINER SIGNATUR for **EXAMIRER'S** (Street (Liver or county)) retained NAME (Type) LOCATION BURIAL, CREMATION. 9 25a. REC'O BY REGISTRAR VR A15ME 350D 4-64



1	em 18 Film 387 4-18-6 MARYLAND STATE DEPARTMENT OF HEALTH
BOTH CTATE	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
PÓR STATE HEALTH DEPT.	02050 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02045
HEALTH DEFT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY
7 8 5 E	Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town)
ssar uner ay I trmei	write RURAL and give nearest town)
is necessary, to the funeral e 5 may be be Department after death.	Sykesville 2 yrs. 11 mos. Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS o. IS RESIDENCE
to the see	Springfield State Hospital 10409 Rodney Road YES NO N
any delay is 7, 2, and 3 to the PM3. Page but the State D in 72 hours af	3. NAME OF First Middle Last 4. DATE Month Day Yeer
M3.and	(Type or print) Margaret Howe Greene DEATH 2/10/67 19 67
ithin (thin)	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS.
with To see S.	All Millionies Park Brighton Park
er dea ive Pa with and event	Famale White Wildowebed Divorced 1/23 1/2 yrs. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY?
after Giv ng v	House wife Own home Oregon U.S.A.
ours aftern 18. Glass along pages 1 in any	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
24 horn litern Office and and	Gordon Hunt. Madge Howe Address
n 2/2	(Yes, no, or unknown) (If yes give war or dates of service) (21 Lanest Greene 9611 New Hampshire Hue.
within pencil ir miner's permit, removal,	1 is Callet of Death [Enter only one cause per line for (s) (h) and (c)]
kami kami it po	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AS Ph / X 1 a
ild be executed "pending" in i if Medical Exan burial-transit i cremation, or i	1555 X
e exe andica dica jal-t	Conditions, If any, which) to OCC (1/SIAN Of Nose, and mouth tou by fow) min.
d bur par	gave 1150 to iniliaritate (1) and the control of th
ate shoul ne word the Chief sed as a burial,	underlying cause last. CC Pre-senile degeneration of the brain PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY
the very sed	PERFORMED.
tifica g the to the ne use	Schizoonrenic reaction Curric undid terent rated the YES NO
cer ritin ded ded	20a. EXTERNAL CAUSE WAS 20b? DESCRIBE HOW INJURY OCCURRED. (Enter neture of hijbry in Part 1 or Part 11 of item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH.
AL EXAMINER. This certificate should be executed within 24 hours after death. If the certificate, writing the word "pending" in pencil in item 18. Give Pages 1 should be forwarded to the Chief Medical Examiner's Office along with form files. Tiles. CTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with designated agent, prior to burial, cremation, or removal, and in any event within	
icate e fo	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20f. (City or town) (County) (State) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20g. PLACE OF INJURY (Home, farm, factory, st
the certification of the certi	21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion
EXA property of the control of the c	death resulted from: Natural causes . Accident ., Suicide ., Homicide ., Undetermined manner .
	ACTUAL CILLED ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED
WEDIG execute Page I for you	SIGNATURE A SIGNATURE DEPUTY MEDICAL EXAMINER 7
HE SELECTION	NAME (Type) Glenn Speicher M.D. had so Grellite ione, by delight fruingly lightly
O DEPUTY please exi director. retained f O FUNERAL of Health	238. BURIAL, CREMATION, 23b. DATE THEREOF , 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
To region of	Burial (Specify) Geb 15, 1967 Arlington National Cemetery Arlington Virginia
	John B. Thomas Judge 8434 Georgia Ave. 25a. REC'D BY REGISTRAR'S SIGNATURE
VR A15ME 3500 4-64	Warner E. Pumphrey, Inc. Silver Spring, Md. DATE FEB 16 1961 Justing -



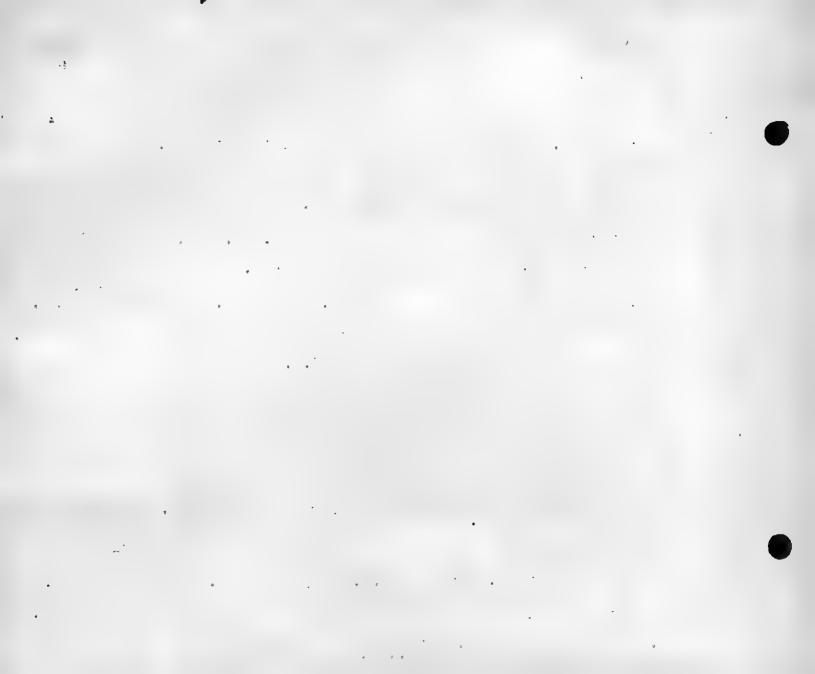
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND 02051 CERTIFICATE OF DEATH hours after death. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) 1. PLACE OF DEATH a. STATE b. COUNTY in and completely filled in by the semoves carbon papers. Pages 1 in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, OF STAY IN 1b write RURAL and give nearest town e. IS RESIDENCE d. STREET ADDRESS ON A FARM? No C executed within NAME OF 3. Middle DECEASED DF DEATH WERS (Type or print) 5. SEX AGE (In years NEVER MARRIED last birthday) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR RTHPLACE (County & State, or foreign country) OCCUPATION (Give kind of work done TO HOSPITAL OR ATTENDING ransours. The hysician.

Page 4 may be retained by the hospital or attending physician.

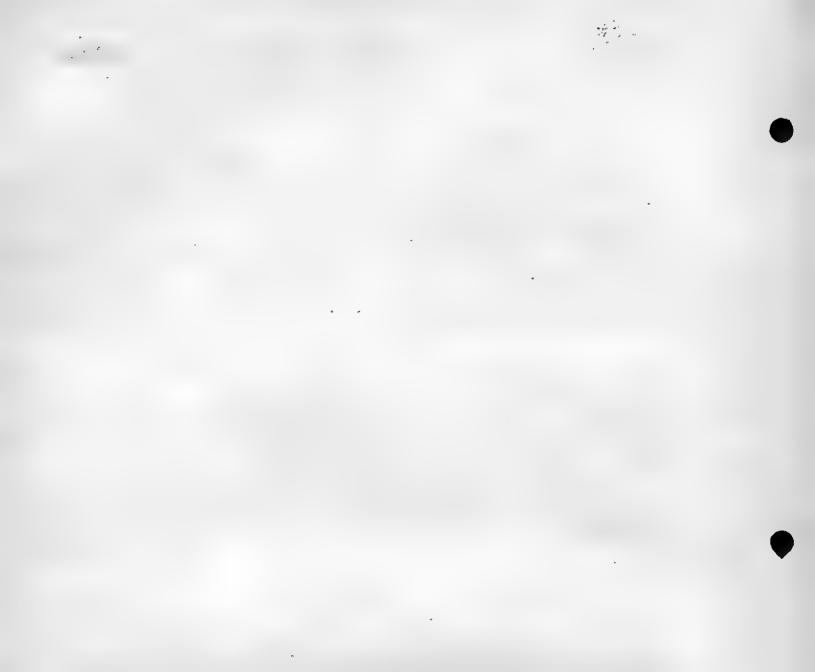
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician director, page 3 should be detached for use as the burial-transit permit. Then please in the state of the plant of the prior to burial, cremation, or removal, and in schmid be filed with the State Dept. of Health prior to burial, cremation, or removal, and in COUNTRY? working life, even if retired) NILSON Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN (If yes plye war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions. If any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last WAS AUTOPSY CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO F YES F 20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) MIDICAL (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While at work attended the deceased from 21. I certify that (I) (this hospital) M. from the causes and on the date stated above. saw the deceased alive on and that death occurred at DATE SIGNED 22b. 22a. SIGNAJURE M.D. 22d. ADDRESS PHYSICIAN'S (State) BURIAL, CREMATION, REMOVAL (Specify) 8 VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET. BALTIMORE 1, MARYLAND OF DEATH death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. COUNTY Baltimore ges 1 after Carrol] the MARYLAND Marvland by the Pages b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN Tif outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b papers. 1-27 pours Finksburg Towson d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADORESS e. IS RESIDENCE ON A FARM? within 72 Sandy Mt. Rd. 1720 Aberdeen Rd NO X etely Pour 3. NAME OF First Middle DATE Month Year DECEASED remove carb (Type or print) DEATH Anna Grason 1967 5. SEX 6. COLOR OR RACE AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS. 7. MARRIED DATE OF BIRTH NEVER MARRIED last birthday) Months I F WIDOWED DIVORCED Ξ 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ding physician Then please r 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT INDUSTRY and COUNTRY? Homemaker USA Balto. Co.. Md. certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal William Grason Anne S. P. Chew ed by the attend transit permit. cremation, or re 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Route Mrs. Ridgely H. Lee Finksburg. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN been signed by t the burial-transit or to burial, crema ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema hrs. Arteriosclerotic C.V. Disease Conditions, If any, which Veare gave rise to immediate cause (a), stating the DUE TO as th underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health p PERFORMED? certificate NO 🔽 YES -PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING I DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) detached file Dept. of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) this MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm.) 20f. (City or town) (County) (State) be de State I factory, street, office bldg., etc.) DIRECTOR: After tage 3 should be de lied with the State Hour a.m. While Not While ATTENDING p.m at work at work be retained 21. I certify that (I) (this hospital) attended the deceased from Manch 6/1 to Feb -Feb.2/1 and that death occurred at I OAM, from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED page 2-28-67 MED, DIRECTOR M.D. may FUNERAL HOSPITAL PHYSICIAN'S ADDRESS director, p 22d. NAME (Type) Strobe] St.Reisterstown. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Prospect Hill Towson Buria] Md . 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 196 & Sons Co. 4905 York VR A15 (4) 20M



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02053 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 haurs after death nd campletely filled in by the funeral emave carban papers. Pages 1 and any event, within 72 hours after deat 2 USUAL RESIDENCE (Where deceosed lived, if institution PLACE OF DEATH b. COUNTY Carroll o. COUNTY Carroll o. STATE Maryland MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown Rural Tanevtown d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Enroute to Hospital Crouse Mill Road YES NO X NAME OF Middle Lost 4. DATE Month Dov Year DECEASED Charles Hopkins 17 167 Howard February (Type or print) DEATH 1 YEAR IF UNDER 24 HRS S SEX AGE (In years IF UNDER 6 COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthdoy) Months Dovs Male White Nov. 13, 1899 WIDOWED DIVORCED 1Do USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 13 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working the even if refired)
Pharmacist Pharmacy COUNTRY? Baltimore City, Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Harry M. Hopkins Bertha Murray 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) 212-07-8220A Mrs.Linda G. Hopkins Taneytown. Md. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse has been as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REMITED TO THE TERMINAL DISEASE CONDITION GIVEN IN WAYALTOPS' PERFORMED? detached far use of Bept. of Health p YES NO O FUNERAL DIRECTOR: After this certificate 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I of Port II of Item 18.) 200 ACC DENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2De. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or town): (County) (Stote) foctory, street, office bldg., etc.) Not While of work L ot work 21. I certify that (1) (this haspital), attended the deceased from 12, 1961, to 46, 17, 1967, that (N) (we) last saw the deceased alive an 36, 17, 1967, and that death accurred at 9:35/M, from causes and an the date stated above. , 19.617, that (N). (we) last saw the deceased alive an 324 17 22o. SIGNATURE 22b. DATE SIGNED MED.
DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) E. Ambler Thompson Taneytown. Maryland director, shauld 23d. LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, (County) REMOVAL (Specify) 2/21/67 Lutheran Cemetery Taneytown, Carroll, Maryland
REGISTRAR | 255. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR ADDRESS VR A15 (4) DATEEB 20 M 1/66 John H. Skiles, C.O. Fuss & Son, Taneytown, Md.



11	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
7	- =0-1	02054 CERTIFICATE OF DEATH 02049			
	24 hours after death filled in by the funeral apers. Pages 1 and 72 hours after each	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)			
	he fi	Carriel Co - MARYLAND BASIANE O. COUNTY CASSAGE			
	by t Page	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)			
	thoull do in class.	d. NAME OF HOSPITAL OR INSTITUTION (if no) in hospital, glow street address) d. STREET ADDRESS (e. IS RESIDENCE ON A FARM?			
	fille pape	ON A FARM? YES TO NO			
	executed within and completely remove carbon in any event, within	3. NAME OF First Middle Last 4. DATE Month Day Year OF OF			
	ed w ompi	(Type or print) / 17 / HLEEN F. /SL/P DEATH FEB // 1967			
	ecut nd co move my e	6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR FUNDER 24 HRS. Last birthday) Months Days Hours Min.			
	e ex an a e re l in a	1DJ. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY?			
	te b	home - wife - manchester mand U.S. a.			
	iffica merch	13. EATHER'S NAME			
	cerf endin t. TI r ren	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT Address Samuelawn			
	requires that the death certificate be ding physician. Been signed by the attending physician the burial-transit permit. Their place or to burial, cremation, or removal, and in the burial, cremation, or removal, and it	(Cres, no, or unknown) (If yes give war or dates of service) ? mahalis norcos			
	he d y the sit p mati	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: ONSET AND DEATH			
	hat t cian. ed b tran tran,	IMMEDIATE CAUSE (a) Cerebrovascukus accident accident			
	ces the sign sign arrial urrial	Conditions, if any, which (b)			
	ing ling losen been to b	gave rise to immediate { cause (a), stating the } DUE TO			
	aw r ttend has b an t prior	underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY			
	fhe for all or all ate use alth	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?			
	AN: J	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
	SICI hosi s ce all he ept.				
	the Date of the Da	2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 4 work 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) 2Dc. PLACE OF INJURY (Home, farm,			
	Afte By Afte By Sta	p.m. 19 at work			
	stain TOR TOR shou	saw the deceased alive on Fit 10 19 67, and that death occurred at FM, from the causes and on the date stated above.			
	OR A be right	22a. SIGNATURE ATTENDING MED. STAFF 22b. DAJE SIGNED M.D. PHYS. DIRECTOR PHYS. 27167			
	TAL may AL Dag	22c. PHYSICIAN'S CILL 22d. ADDRESS CILL 4. 1 [M.]			
	O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detailed for use a the burial-transhould be filed with the State Dept. of Health prior to burial, cre	Dicor O receipt			
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detailed for use all the burial-transit permit. Their place remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after each	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)			
		24. FUNERAL DIRECTOR ADDRESS 25a. REGISTRAR 25b. REGISTRAR'S SIGNATURE			
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND DEATH CERTIFICATE OF funeral and 2 hours after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY ses 1 after by the MARYLAND Pages CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) c. LENGTH OF STAY IN 1b oon papers. Pag within 72 hours lanches ter completely filled in e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? 24 NO M YES executed within carbon 3. NAME OF Middia 4. DATE Month Day Year DECEASED OF event, OWN ÖEATH 196 (Type or print) DATE OF AGE (In years | IFUNOER 1 YEAR HF UNGER 24 HRS SEX 6. COLOR OR RACE remove 9, 7. MARRIEO NEVER MARRIED last birthday) Months Days lease Temov and in any 6 Hours and a WIDOWEO DIVORCEOF Vrs. 12. CITIZEN OF WHAT 101. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11, BIRTHPLACE (County & State, or fereign country) cian 10b. KIND OF BUSINESS OR **COUNTRY?** INDUSTRY has been signed by the attending physical sas the burial-transit permit. Then ple prior to burial, cremation, or removal, as The law requires that the death certificate, 13. FATHER'S NAME MOTHER'S MAJOEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN' Address (Yes, no, or unknown) | (Myes give war or dates of service) INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for ONSET AND CEATH PART I. DEATH WAS CAUSED BY 2 Kar D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that tip Page 4 may be retained by the hospital or attending physician. IMMEDIATE CAUSE (a DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. certificate hithed for use at PERFORMED? CAT NO 🔽 YES DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING t be detached for State Dept. of H OR CONTRIBUTING CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER) OR: After this could be detach the State Dept. (State) MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Cay, Year factory, street, office bldg., etc. Hour a.m. Not While at work While 19 at work p.m. FUNERAL DIRECTOR: A firector, page 3 should hould be filed with the Kthis hospital 21. I certify that (I) attended the deceased from and that death occurred at 9:3. from the causes and on the date stated above. saw the deceased alive on DATE SIGNED 22b. 22a. SIGNATURE STAFF page ATTENDING M.O. PHYS DIRECTOR PHYS O HOSPITAL 22d. ADDRESS PHYSICIAN'S director, p should be NAME (Type) (State) LOCATION (City, town or county) NAME OF CEMETERY OR CREMATORY 23d. SURIAL, CREMATION, **OATE THEREOF** 23b. REMOVAL (Specify) 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 25a. Willowels VR #15 (4) DATE 20M 1/65

LAND STATE DEPARTMENT OF HEALTH



	Division of STATISTICAL	MARYLAND STATE DEF RESEARCH AND RECORDS, 301			21201
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The law requires that the death certificate be executed within 24 hours after death attending physician. has been signed by the attending provision and campletely filled in by the funeral se as the burial-transit permit. Liper please remove carbon papers. Pages 1 and the priar ta burial, cremation, or remayal, and in any event, within 72 haurs after death.	18. CAUSE OF DEATH (Enter on y one cause per PART I. DEATH WAS CAUSED 89. IMMEDIATE CAUSE (a)	line for (o), (b), and (c))	eratic C.	VD /	INTERVAL BETWEEN ONSET AND DEATH
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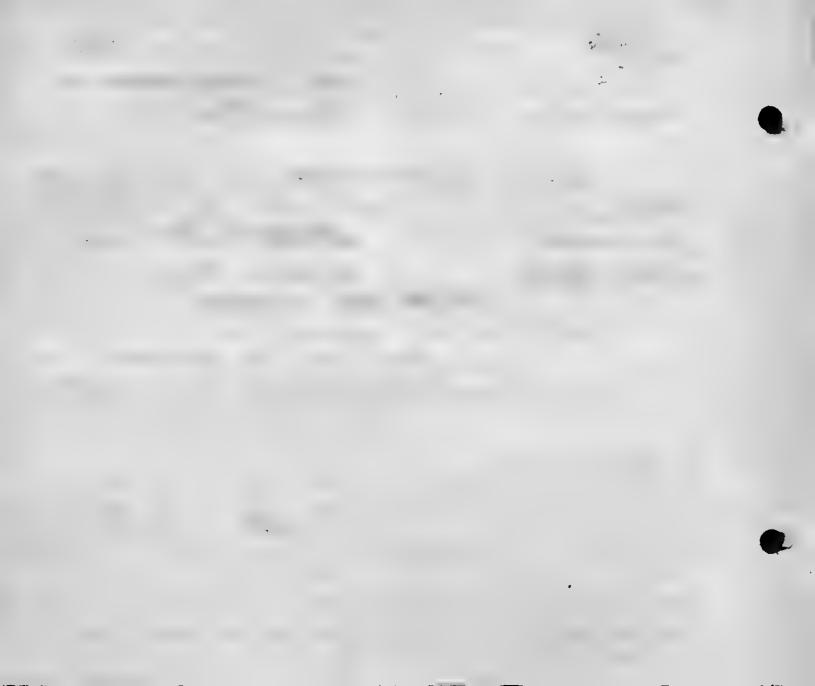
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 02057 law requires that the death certificate be executed within 24 hours after death signed by the attending physicion and campletely filled in by the funeral burial-transit permet Men please remove carbon papers. Pages I and burial, cremation of papers. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY o. STATE **6 COUNTY** Carroll Maryland MARYLAND Talbot papers. Pages 1 hin 72 haurs after b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1h. c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville 27days Queen Anne d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Springfield State Hospital YES NO X NAME OF Middle 4 DATE event, wit Lost Month Dev Year DECEASED DECEASED (Type or print) SARA BARTON Jump 1967 DEATH S SEX 6 COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED birthdoy) Months Dovs Hours 11/30/78 white WIDOWED X female DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 1220 COR GLUO 15 WAS DECEASED EVER IN L.5 ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 17. INFORMANT Springfield Hospital records, Sykesville, Md. IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), INTERVAL RETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY Cardiac failure IMMEDIATE CAUSE (o) 4001 DUE TO Conditions, if only, which gove Myocardial infarction davs rise to immediate couse (a), DUE TO stating the underlying couse use as the l by the haspital or attending has been lost. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS! PERFORMED? Paranoia. NO O FUNERAL DIRECTOR: After this certificate ģ 20g ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) TIME OF INJURY Month, Dov. Year Hour o.m. factory, street, office bldg., etc.) Not While at work of work 197 , that (XC (we) last 21. I certify that (1944this haspital) attended the deceased fram. 19.34 , ta Page 4 may be retained shauld and that death accurred abs. 15a M, from causes and an the date stated above. 2/8/ 1967_, saw the deceased alive an 22o SIGNATURE 22b DATE SIGNED **ATTENDING** 2/8/67 director, page 3 shauld be filed v M.D. DIRECTOR PHYS Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Edmee J. Reeves, M. D. NAME (Type) Svkesville Marvland 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City_or Town) 230. BURIAL, EREMATION, 23b. DATE THEREO! (County) (Stote) REMOVAL (Specify) FREENMOUNT ISLORO Md. FUNERAL DIRECTOR 250. REL'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 antes Puda DATE

MARYLAND STATE DEPARTMENT OF HEALTH



W. PRESTON STREET, BALTIMORE 1, MARYLAND funeral should PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY MARYLAND b. CITY OR TOWN (if pulside corporate limits, c. LENGTH OF STAY IN 1b OR TOWN (If outside corporate I-mils, write RURAL and give pearest town) write RURAL and pive negrest town! d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street addless) d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO 3. NAME OF 4. DATE Middle Last Month Day DECEASED (Type or print) DEATH 19 and cor 890 AGE (In years | IF UNDER I-YEAR 5. SEX DATE OF BIRTH IF UNDER 24 HRS. 6. COLOR 7. MARRIED WINEVER MARRIED last birthday) Days Months Hours NOV WIDOWED [DIVORCED [USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if retired) 13. FATHER'S NAME 16. SOCIAL SECURITY NO 3. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unkown) | (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gava rise lo immadiata cause (a), stating the underlying PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 1 19. WAS AUTOPSY PERFORMED? NO TH 20a. ACCIDENT WAS UNDERLYING [] 20b DESCRIBE HOW INJURY OCCURED, (Enter nature of 'n'ury in Part) or Part If of Item 18) OR CONTRIBUTING CAUSE OF DEATH (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED , 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Whife Not While Hour a.m. at work at work p.m. 21. I certify that (I) (this hospital) attended the deceased from 1966 M, from the causes and on the date stated above. saw the deceased alive on..... ... and that death occurred at 1/ SIGNATURE 22b. DATE ATTENDING: DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Hampstead Md. M. C. Porterfield NAME (Type) 23d. LOCATION (City, lown or county) 23a, BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) Mid. REMOVAL (Specify) REGISTRAR'S SIGNATUR 24 FUNERAL DIRECTOR'S



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before edmission a. COUNTY b. COUNTY 투원 Carroll MARYLAND 217 7 Janua 11 and b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) within 24 write RURAL and give nearest town) .5 Pages Years Rupol - Pinke nro d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street eddress) hours d. STREET ADDRESS . IS RESIDENCE ON A FARM? Poute completely Route YES NO 72 3. NAME OF Middle 4. DATE DECEASED OF (Type or print) DEATH February 9 . 19 carbon withi 5. SEX and B. DATE OF BIRTH 9. AGE (In yeers | IF UNDER 1 YEAR 7. MARRIED THE NEVER MARRIED IF UNDER 24 HRS lest birthdey) WIDOWED DIVORCED physician гетоме 10a. USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUSTRY (1) BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if retirad achirint II.S.A. 13. FATHER'S NAME Duing Albert S. Lindsay Bertie A. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) ((fyesgivewerordates of service) 1B. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: cremation, IMMEDIATE CAUSE (e) burial-transit **DUE TO** peen Conditions, if any, which gave rise to immediate cause DUE TO (a), stelling the underlying the After this certificate the hospital PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PAJ detached for use as CERTIFICATION WAS AUTOPS PERFORMED? NO 20a, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Entar nature of Injury in Part 1 or Part II of Itam 18.) OR CONTRIBLTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be retained by 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED : 20e, PLACE OF INJURY (Home, farm,) 20f. (City or town) (Stelle) (County) factory, street, office bldg., etc.) While Not Whila DIRECTOR: State Dept. at work et work 21. I certify that (I) (this hospital) attended the deceased from. pluods saw the deceased alive on and that death occurred at 2/2 M, from the causes and on the date stated above 22a. SIGNATURE DATE 22b ATTENDING MED STAFF SIGNED HOSPITAL with th PUNERAL PHYS. DIRECTOR PHYS. M.D. 22c. PHYSICIAN'S 22d. ADDRESS filed v NAME (Type) P. g. g 23e. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) REMOVAL (Specify) 24 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 25a, REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 [4] Sykesville. DATE 20M 5-63

DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 02060 FOR STATE MEDICAL EXAMINER'S CERTIFICATE HEALTH DEPT. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY CARROLL CARROLL MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 10 the funer 5 may b WESTMINSTER ESTMINSTER d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADORESS e. IS RESIDENCE ON A FARM? delay is ind 3 to 1 56 JOHN NO 7 YES! and 3. NAME OF First Middle Last DATE Month DECEASED (Type or print) DEATH 2 with with within 5. SEX 6. COLOR OR PACE DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS NEVER MARRIED Z 7. MARRIED last birthday) | Months | Hours FEMALE WICOWED J **OIVORCED F** and sevent 1Da. USUAL OCCUPATION (Give kind of work done | 1Db. KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? U.S.a. DOMESTIC 13. FATHER'S NAME LIZZIE POOLE LOUIS B. LINTON and 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address SAME (Yes, no, or unkown) ((If yes nive war or dates of service) permit. | removal, INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH PART 1. CEATH WAS CAUSED BY: burial-transit cremation, or IMMEDIATE CAUSE (a) cremation, DUE TO Conditions, if any, which (b) gave rise to immediate **OUE TO** cause (a), stating the underlying cause last. used as to burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO N YES 20a. EXTERNAL CAUSE WAS DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. should ent, pri 3 shou agent, MEDICAL 2Dd. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm,) 2Df. (Clty or town) (County) (State) 2Dc. TIME OF INJURY Month, Oav. Year factory, street, office bldg., etc.) Hour a.m. While - Not While at work at work and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy Inspection M. Inquiry the cen should Natural causes [X]. Undetermined manner death resulted from: Suicide Homicide CHIEF MEDICAL EXAMINER YOUL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 0 DEPUTY MEDICAL EXAMINER **EXAMINER'S** retained director. NAME (Type) LOCATION (City, town or county) NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. DATE THEREOF 23c. REMOVAL (Specify) 0 Co SURIAL FUNERAL DIRECTOR VR A15ME 350D 4-64

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Par to	b. CITY OR TOWN life outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN/III outside corporate limits write RURAL and give neerest town)
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Pa Pa	FAIRMOUNT ROOM PORD. VESTINOS
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MARYLAND STATE DEPARTMENT OF HEALTH

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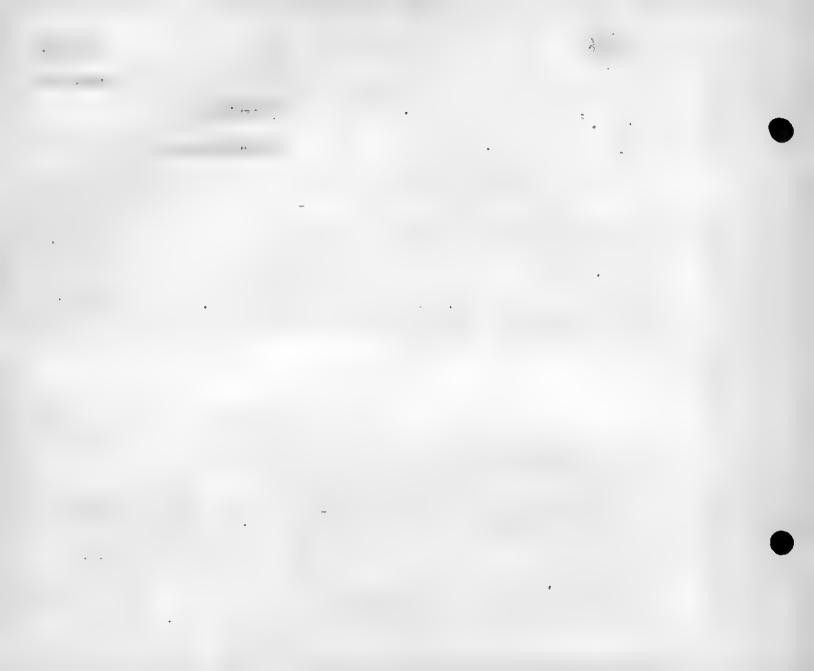
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02062 requires that the death certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution Residence PLACE OF DEATH o. COUNTY **b** COUNTY Carroll Maryland Carroll MARYLAND b CITY OR TOWN (If outside corporate imits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Taneytown 20 years Tanevtown. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A STREET ADDRESS ON A FARM? YES NO W. Baltimore Street W. Baltimore Street 3 NAME OF Middle 4 DATE Year DECEASED (Type or print) Wilbur Naylor, Sr February George S SEX B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED NEVER MARRIED burthdoy) Male White Sept. 9, 1901 WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10p USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired) INDUSTRY Farming Frederick Co., Maryland 14. MOTHER S MAIDEN NAME 13 FATHER'S NAME Maude Estelle Stull George C. Naylor signed by the attending 17 INFORMANT IS WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) ((If yes give wor or dotes of service Mrs. Ruth Naylor, W. Balto. St.. No IB. CAUSE OF DEATH (Enter only one couse per fine for (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Conditions, if ony, which gove rise to immediate couse (o), storing the underlying couse WAS AUTOPS PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o NO X 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of Item 1B.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (1F EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) 2Dc TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While O FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased from Hand with a sew the deceased glive an February and that death accurred at 1110 pm, from causes and an the date stated above saw the deceased alive an 3 sh 22b. DATE SIGNED 22o. SIGNATURE DIRECTOR 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) HOMPS ON 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 230 BUR AL CREMATION REMOVAL (Specify) Keysville, CarrollCe., Md. Kevsville Cemetery 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE FLINPRAY DIRECTOR Taneytown, Md. John H. SkilesDATE & Son



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (if outside/corporete limits, write RURAT end size new street eddress) C. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)	before edmission) eresi town) e. IS RESIDENCE ON A FARM? YES \(\sum_{Year} \) NO \(\sum_{Year} \)
a. COUNTY b. CITY OR TOWN (if outside/corporate limits, c. LENGTH OF STAY IN 1b c. CITY OF TOWN (if outside/corporate limits, write RURAT and sive no stay in the rest of sive nearest lown) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS J. NAME OF COUNTY Month Day Month Day Month Day	e. IS RESIDENCE ON A FARM? YES NO
b. CITY OR TOWN (It outside corporate limits, write RURAT and sive no difference limits, write RURAT and sive n	e. IS RESIDENCE ON A FARM? YES NO
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) Crys View Hame Street ADDRESS 3105 (John Morth Day Morth Day	ON A FARM? YES NO NO
J. NAME OF Surst / Models State LA DATE Month Day	Yeer
DECEASED (Type or print) PIZO herry Pentrum I	19 6 /
	IF UNDER 24 HRS. Hours Min.
196. USUAL OCCUPATION (Give kind of work look indigence of the state of sta	WHAT COUNTRY?
13. FATHER'S NAME 13. FATHER'S NAME 14. WOTHER'S MAIDEN RAME 14. WOTHER'S MAIDEN RAME 15. WOTHER'S MAIDEN RAME 16. WOTHER'S MAIDEN RAME 17. WOTHER'S MAIDEN RAME 18. WO	O./E'
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) [(Hyes give wer or dates of service) 117-23-1833 (2) 1-10 5510 (2) 11 10 10 10 10 10 10 10	1 Just
PART I. DEATH WAS CAUSED BY:	RVAL BETWEEN ET AND DEATH
IMMEDIATE CAUSE (a) List of the conditions, if any, which \ (b)	5
geve rise to immediate cause (a), stating the underlying DUE TO	
PART II. OTHER SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ((a) 19.	WAS AUTOPSY PERFORMED?
206. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Pert I or Pert II of flom 18.) OR CONTRIBUTING CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Dey, Yeer While Not While factory, street, office bldg., etc.) While Not While factory, street, office bldg., etc.)	Stefe)
21. I certify that (I) (this hospital) attended the deceased from 1962 to 2—1, 1962 to saw the deceased alive on 1962, and that death occurred at 1989, from the causes and on the date	
220. SIGNATURE ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. D	22b. DATE SIGNED
22c. PHYSICIANYS NAME (Type) 22d. ADDRESS 12d. ADDRESS	m d
0000 Bureal 2-4-1967 Mit Chirc Country Haudel Colour,	Wed-
VR A15 (4) The Prince of the P	JRE

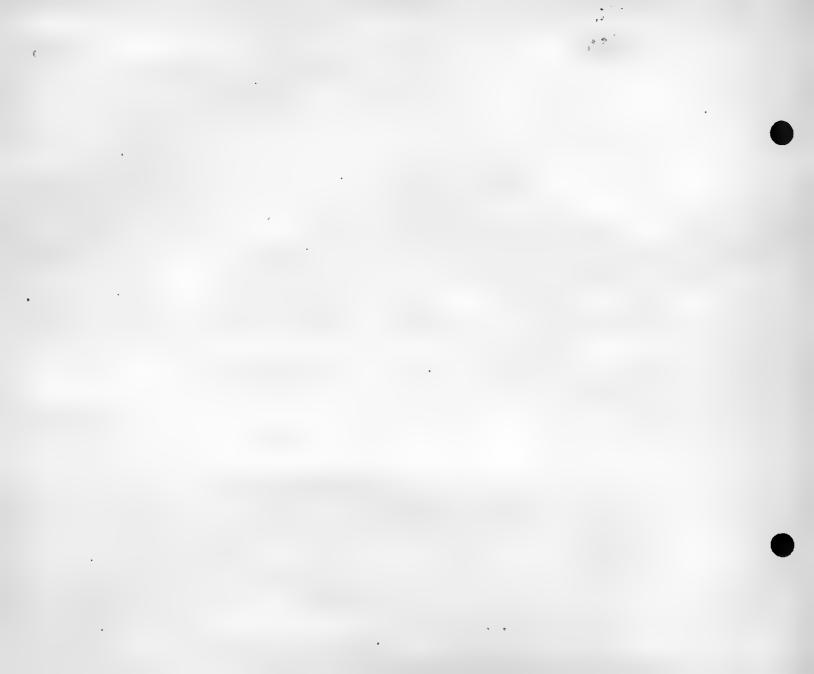


MARYLAND STATISTICAL RESEARCH AND RECO	STATE DEPARTMENT OF HEALTH CORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
X 02064 Item 2 Film G38 CERT	ORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 ORDS 1516 OF DEATH ORDS 12059	
1 PLACE OF DEATH O COUNTY Carroll County MA	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE aryland Carrett	
b CITY OR TOWN (If outside corporate 1 mits, Syke's VII 1 of give Mary 1 and 9mons. 2	AY IN 1b c CITY OR TOWN 1 for trade compressed in its write RURAL and give nearest town)	
d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) Springfield State Hospital	d STREET ADDRESS 3220 Carlisle Ave. S. RESIDEN ON A FARM SVI - Springfield/State/Hospi/tal/ES NO	NCE M?
3 NAME OF First Middle DECEASED (Type or print) Louise May	Pirie OF February 5 19 67	7
S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARR Female White WIDOWED DIVORCE	☐ ☐ 7 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	4 HRS Min
10a USUA_OCC_PATION (Give kind of work dane during most of working life, even it retired) Beautician 10b. KIND OF BUSINESS OR INDUSTRY	Maryland COUNTYS.A.	
13 FATHER'S NAME Henry J. Pirie	14. MOTHER'S MAIDEN NAME Isabel McCoy	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, no. or unknown) [Iff yes give war ar dates at service] 216-05-1215	O. 17 INFORMANT Hospital Records. Address ykeswille and	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Out the control of	O Sec Fla INTERVAL BETWEE	EEN ATH
Canditians, if any, which gave rise to immediate couse (a), storing the underlying cause last. DUE TO (b) C12 S (148) DUE TO PRICE TO CONTROLLED TO CONT	Laction distinct with	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT R	PERFORMEU	Şγ Σ 🔀
200 ACCIDENT WAS UNDERLYING COR CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTION CAUSE OF DEATH OF CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTION CAUSE OF DEATH O	Y OCCURRED (Enter nature of injury in Port I or Part II of item 18.)	
p.m. 17 at wark 🗀 at wark 🗀	20e. PLACE OF INJURY (Home, form factory, street, affice bldg., etc.) 20f (City or town) (County) (Sto	ote)
21. I certify that (I) (this hospital) attended the decease saw the deceased alive on 2-11-1967	_, and that death accurred aB:15AM, from causes and on the dote stated o	e) los abave
Luis & Caral	M.D. ATTENDING MED. STAFF 226 DATE SIGNED M.D. PHYS DIRECTOR PHYS. Z 2-5-67	
22c. PHYSICIAN'S NAME (Type) Dr. Casal	22d ADDRESS	
REMOVAL (SPREATY) 2/9/1967 Loudo	EMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State on Park Cemetery Baltimore, Maryland	ie)
Who. A. 7 when I some horther	250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE LANGES DATE FFR 6 1987 Aclientles Judges	Ł



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02065 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death signed by the attending physician and completely filled in by the funeral burial-transit permit. Then pedses remave carban papers. Pages I and 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission I PLACE OF DEATH a. COUNTY o. STATE **b.** COUNTY Carrol? MARYLAND Marvland Carroll b CITY OR TOWN (If autside carparate | mits, c LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Westminster, 2 hours Westminster d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? NO J Carroll Co. General Hospital 64 Winchester Avenue YES [3 NAME OF Middle First Last DATE Day Year DECEASED Charles Luther Pittinger 27 DEATH February 19 67 (Type or print) S SEX 6 COLOR OR RACE DATE OF BIRTH AGE (n years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED birthday Months Hours Male White WIDOWED October 6, 1892 DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY **COUNTRY?** Laborer Frederick County, Maryland
14. MOTHER'S MAIDEN NAME II.S 13 FATHER'S NAME ar remova Samuel B. Pittinger May Winter 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 64 Add Winchester Ave. 16. SOCIAL SECURITY NO. (If yes give wor at dates of service) Mrs. Lillie Pittinger, Westminster, Maryland 212-14-6789 1B. CAUSE OF DEATH (Enter any one cause per line for (o), (b), and (t)) PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Cer. brok Herondonia Canditians, if any, which gave (b) rise ta immediate cause (a), DUE TO stating the underlying cause the O FUNERAL DIRECTOR: After this certificate has been last. OS 19. WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO T by the hospital ar for 20g ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City ar town) (County) (State) Hour a.m. factory, street, office bldg , etc.) Not White at wark 2). I certify that (1) (this haspital) attended the deceased from Feb 27, 19, 67, to Feb 27, 1997, that (1) (we) last be ratained o saw the deceased alive an Feb 27. 19 67, and that death accurred at 114 M, from causes and an the date stated above. 226 DATE SIGNED 22a. SIGNATURE ATTENDING M.D PHYS -DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S SHEY NAME (Type) director. should 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL, CREMATION. 23b. DATE THEREOF REMOVAL (Specify)
Burial Winters Cemetery Linwood Carroll Maryland 256 REGISTEADS SIGNATURE 2So. REC'D BY REGISTRAR ADDRESS Taneytown, 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 C.O.Fuss & Son (John H. Skiles)

MARYLAND STATE DEPARTMENT OF HEALTH



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
E 70	02066 CERTIFICATE OF DEATH 02061
after death. the funeral ges 1 and 2 after death.	1. PLACE OF DEATH a. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admiss b. COUNTY MARYLAND MARYLAND
certificate be executed within 24 hours after death now, physician and completely filled in by the funeral Hen please remove carbon papers. Pages 1 and 2 removal, and in any event, within 72 hours after death	b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) 4 ms - 2 who d. NAME DF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDED ON A FARM
cely fille on pape vithin 72	3. NAME OF First Middle Last 14 DATE Month Day Year
uted wit complet ve carb event, v	DECEASED (Type or print) 5. SEX 6. CDLOR DR RACE 7. MARRIED NEVER MARRIED 8. DATE DF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24
nte be executed within yysician and completely please remove carbon plant and in any event, with	Famel What WIDOWED DIVORCED her 4, 1888 last birthday) Months Days Hours M 10a, USUAL DCCUPATION (Give kind of work done 10b, KIND OF BUSINESS DR during most of working life, even if retired) 10b, KIND OF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN DF WHAT CDUNTRY?
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	15. VAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes/no, or unknown) (If yes give war or dates of service) 2/3 U.S. / 28 have great forces (Lample) Wrating and the second forces of service)
of the de ian. d by the ransit pe crematio	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Branche - Archive -
quires that physicions physicions signes on signes on the physicion to purial-to puria	Conditions, if any, which gave rise to Immediate cause (a), stating the DUE TD D 1 to 2 1 to
CIAN: The law re ospital or attendi certificate has be hed for use as th t. of Health prior	Underlying cause last. (c) WAS AUTOP PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOP PERFORMED YES NO. 1
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NG by fter be stat	20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY DCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 19 at work
E 2 4 0 0	21. I certify that (1) this hospital) attended the deceased from Oct 15, 1966, to 7 eb 27, 1967, that (1) (we) saw the deceased alive on 2/26, 1967, and that death occurred at 19 M, from the causes and on the date stated above 22a. SIGNATURE
i Se ii Se	22c. PHYSICTAN'S NAME (Type) 1/1 + F. A. J. A. DIRECTOR STAFF 2/27/67
O HOSPITAL Page 4 may O FUNERAL E director, pag should be fill	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c, NAME DF CEMETERY DR CREMATORY 23d. LDCATION (City, town or county) (State)
	24. FUNERAL DIRECTOR ADDRESS 252. DEC'D BY REGISTRAR 25b. AEGISTRAR'S SIGNATURE
20M 1/65	J- 2 Myles fo- West provider MAR 2 1967 foliarlas Judge



1		Division of STATISTICA		RYLAND STATE H AND RECORDS,			ALTH Et, Baltimore, Maryi	LAND 21201	
attending physician. has been signed by the attending physician and completely filled in by the funeral ise as the burial-transit permit. Then please remove carban papers. Pages I and 2 the prior to burial, cremation, or removal, and in any event, within 72 hours after death.	02067			CERTIFICA	TE (OF DEATH		020	062
e funeral es 1 and ifter death	1. PLACE OF DEATH o. COUNTY Ga	rroll		MARYLAND LENGTH OF STAY IN 16	2	o STATE Maryland	There deceased lived, if institution in the COU Ballstade corporate limits, write RU	Ltimore C	lity
n by th s. Page hours a	Sykes	(If outside corporate limits, id give nearest tawn) VIIIe TAL OR INSTITUTION (If not in	Ъ.	3vrs.lmo.l	dys	,		The same give the same	, ,
in 72		gfield State		· · · · · · · · · · · · · · · · · · ·			reene St.		ON A FARM? YES NO X
event, with	3 NAME OF DECEASED (Type or print) S. SEX	First WILLT 6 COLOR OR RACE 7	AM MARRIED	Middle (NMN) NEVER MARRIED		Lost DESKY DATE OF BIRTH	9 AGE (In years	RUARY 18 FUNDER 1 YEAR Months Doys	19 67 IF UNDER 24 HRS.
	Male 100 JSUAL OCCUPATION during most of worken Facti 13. FATHER'S NAME	N (Give kind of work done	IOP KIND (DIVORCED [DF BUSINESS OR IRY Louce		April, 189 11. BIRTHPLACE (County II Marylance 4. MOTHER'S MAIDEN N	& Stote, or foreign country)	12. CITIZEN C COUNTRY U.S.A	DF WHAT
Then personal,	Israe	al Radesky	116 5051	AL SECURITY NO			r Cohen	n/e	
ermit. in, or re	{Yes, no, or unknown; N O	(If yes give war or dates of ser	220-	54-6659			ngfield State	Hospita]	
director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 3 should be dited with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death distributions.	1B. CAUSE OF PART I. DE PART I. DE PART II. DE PART III. DE PAR	te couse (o), ((b), ond (c)) hopneumoni	a			9.	MERVAL BETWEEN NSET AND DEATH DAYS
alth pric	PART II OTHER	ignificant conditions control phrenic reacti	on, he	bephrenic	type	€			WAS AUTOPSY PERFORMED? YES NO X
t, of He	OR CONTRIBUTIN	AS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER)					Part I or Port II of item 18)		
ate Dep	B Hour d	.m. 19	While of work	Not While at work	foctory,	OF INJURY (Home, form, street, office bldg., etc.)		(County)	(State)
the St	saw the	ify that (I) (this haspite deceased alive an <u>2</u> —1	l) attended 18-67	the deceased fran 19, and	h <u>l-</u> that d	-5-211 , 1 leath accurred at	1:30 M. fram causes	and an the do	that (i) (we) last ite stated abave.
director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to	220. SIGNATUR	the 166 (Emp	10.	M.D	22d. ADDRESS S	Springfield St		57
ld be	NAME (Typ	Agustin del	Campo,	M. D.	00.705		Sykesville, Ma		hi) (Centa)
shou	230 BURIAL, CREMAT REMOVAL ISPOCI BUTLAL 24 FUNERAL DIRECT	2/22/67		Rodse Zede ADDRESS			Baltimor		and
(4) /66		nson & Bros.	Inc.,		, R		B 2 4 1967 8	Charles	ynoge



1	MA Division of STATISTICAL RESEARC	RYLAND STATE DEPA' H AND RECORDS, 301 W		MORE, MARYLAND 2120)1
2 4	02068	CERTIFICATE (OF DEATH	02	063
and death	PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if autside carparate limits, c.	MARYLAND	USUAL RESIDENCE (Where decease or STATE Maryland CITY OR TOWN (If guitside carpara	b COUNTY Baltimor	e City
by t Particular	Sykesville d NAME OF HOSPITAL OR INSTITUTION (1f not in hasp tal, give	18 dys.	Baltimore STREET ADDRESS		T e IS RESIDENCE
n 72	Springfield State Hospital	street address)	2926 Harford R	oad	e IS RESIDENCE ON A FARM? YES NO
4 3	NAME OF First DECEASED (Type or print) ROSE	Middle (NMN) R	Lost 4. DATE OF DEATH	Month FEBRUARY	Day Year 22 19 67
5	Female White WIDOWED	NEVER MARRIED B D	-25-1886	AGE (n years IF UNDER	YEAR IF UNDER 24 HRS Doys Hours Min
10 du	ing most of working de, even if retired) INDUS Housewife -	OF BUSINESS OR TRY	II BIRTHPLACE (County & State, or fo Maryland	re y wintry) 12 CITI COU	ZEN OF WHAT NIRY? U.S.A.
movol,	John Meyer	14	Mary Uncleb		
, or re	es, na, or unknown) (If yes give war or dotes of service) Un		ords, Springfie	Address 1d State Hospi	
burial, transit permit. Then please, temove carban papers. Pages I burial, cremation, or removal, oad pany event, within 72 hours after	PARY DEATH WAS CALSED BY IMMEDIATE CAUSE (a) Carci DUE TO the 1	noma of the le	ft lung with me	tastasis to	INTERVAL BETWEEN ONSET AND DEATH MONTHS
prior to burial	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute DUE TO (c)	embolism, rig	ht lung		hours
/ /	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO D	EATH BUT NOT RELATED TO THE	TERMINAL DISEASE CONDITION GIVE	N IN PART 1(a)	19 WAS AUTOPSY PERFORMED? YES 🔀 NO
t, of Health p	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	·	er nature of injury in Port I or Por		
with the State Dept.	Haur o.m. 19 While p.m. 19 at wark	Nat While factory,	OF INJURY (Home, farm, street, affice bldg., etc.)	(City or town) (Cour	
the St	21. I certify that (I) (this haspital) attended saw the deceased alive on 2-22-67	the deceased fram2. 19, and that de	-)1-67 , 19 eath accurred a5:05 B	a 2-22-67, 19 If fram causes and an th	, that (I) (we) le e date stated abor TE SIGNED
de 3 sh ded wit	220 SIGNATURE Tour Tour E.	1 Clic Ma	ATTENDING MED DIRECTOR		3-67
director, page 3 should be detoched for us should be filed with the State Dept. of Health wit	22c. PHYSICIANS NAME (Type) Antonius Glahn,		Sykesvi	lle, Maryland	
nous p	D. BURIAL, CREMATION, REMOVAL (Specify)	Western	Bal	timore,	Caunty) (Stote)
10, 12	G. Howard Ctr 3007 W.	ADDRESS	2Sa. REC'D BY REGISTS DAFFR 9 7		GNATURE Quedge

	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
(18	OSOSO CERTIFICATE OF DEATH Reg. Dist. No. 0206
1.	PLACE OF DEATH o. COUNTY Carroll ARYLANO 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE I Carryland b COUNTY HOVARd
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
L	Union Bridge 4 Years Ellicott City
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TO TON NUTSING HO. 18 4. STREET ADDRESS ON A FARM YES NO
3.	NAME OF First Middle Lost 4. DATE Month Day Year
1	DECEASED (Type or print) Ernest Abby Ridgely DEATH Feb. 16. 196
5.	. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In yours IF UNDER 1 YEAR IF UNDER 24 F
	liale White widowed X DIVORCED Oct. 19. 1900 Oct. Months Doys Hours Min
10	Ou USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUR
	during most of working life, even if retired) Farming Maryland USA
13	3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
114	Edward Kidgely Catherine Burns 5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
	Yes, no or unknown) (If yes, give wor or dates of service)
-	NO ——— Mrs. Forrest Peddicord Harriottsvil 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), ond (c).] INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying couse last. (c)
NOITACIBITATION	
AMEDICAL	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour a. m. 19 While Not white at work at wo
	21. I certify that I attended the deceased fram. 3/14/19, 19, 10, 1944, that I last saw the dece alive on 2/14/67, 19, and that death occurred at 7/4 M, fram the causes and an the date stated at
	ACTUAL SIGNATURE 711, E. Robertson M.D. New Win Assor, 1806 2/14
	PHYSICIAN'S ME-Robertson
10	20 BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY, 22d LOCATION (City. Town, or county) REMOVAL (Specify) 2-18-67 St. John's EMETERY Ellicatt City, Mcl.
23	3. FUNBRAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS DATE DO 1967 GUARDES JUNGE DATE DO 1967 GUARDES JUNGE



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral should hours afte 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before admission) a. COUNTY b. COUNTY \$74 4 Carroll Maryland MARYLAND Carroll b, CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL and give neerest town) Middleburg Rural Taneytown 4 vears d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES 🔚 NO Brookfield Manor Nursing Home pietely 3. NAME OF 4. DATE Month Dev Yeer Last DECEASED (Type or print) DEATH 1967 Gertie Ridinger Mav February and c AGE (in years (IFUNDER TYEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH IF UNDER 24 HRS. lest birthday) Months Female. White Sept.11.1887 WIDOWED DIVORCED certificate physician 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. B RTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Co. Maryland None 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME death John Ridinger Clara Shoemaker Then F 15. WAS DECEASED EVER IN J.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address [Yes, no, or unknwn] [If yes give war or dates of service] requires that Vern H. Ridinger None RFD, Taneytown, Md. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line-for (e), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) **DUE TO** Conditions, if any, which geve rise to immediate cause DUE TO (e), steting the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6): 19. WAS AUTOPSY CERTIFICATION PERFORMED? Jun drone 20b. DESCRIBE HOW NIJRY OCCURED, (Enter neture of injury in Pert 1 or Pert II of item 18.) 20a, ACCIDENT WAS UNDERLYING 1.1 OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d, INJURY OCCURRED 20e, PLACE OF INJURY (Home, ferm, (Steta) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) factory, street, office bldg , etc.) While Not While Hour e.m. el work et work 10.... .l., 19....., that (I) (we) last saw the deceased aliveron.... 22b. DATE 228. SIGNATURE SIGNED ATTENDING . PHYS. DIRECTOR M.D. 22c. PHYSTCIANS 22d. ADDRESS NAME (Type) J.H. Caricofe Union Bridge, Md. 1 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23e, BURIAL, CREMATION, 23b. DATE THEREOF (Stete) 5 # 5 # 3 REMOVAL (Specify) Burial United Brethern Cemetery Taneytown, Marvland 25e. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** VR A15 (4) 15M 7,61 C.O. Fuss & Son, Taneytown, Md. DATE F Skiles

RYLAND STATE DEPARTMENT OF HEALTH



4	MARYLAND STATE DEPARTMENT OF HEALTH	
	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, 2071 CERTIFICATE OF DEATH	02066
	a. COUNTY Carriel MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institutions a. STATE b. COUNTY Carriel MARYLAND	Residence before edmission)
	b. CITY OR TOWN (if outside corporate limits c. LENGTH OF STAY IN 16 write RURAL and give neerest town) ANCH CATE Md. + Who Take Cal	nd g ve neerest town)
71	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Long Vier nursing Home RFD	is residence on a farm? YES NO
i.	3. NAME OF DECEASED (Type or print) MARGAROF Alice Riley DEATH First	17 1967
	5. SEX 6. COLOGOR RACE 7. MARRIED RIEVER MARRIED 8. DATE OF BIRTY 9. AGE (In years IF UNDER less birthday) Months Mont	Days Hours Min.
1	100. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) 100. KIND OF BUSINESS OR INDUSTRY 117 BIRTHP. ACE (County & State, or loreign country) 12. Cl	STIZEN OF WHAT COUNTRY
	13. FATHER'S NAME Junes Martini Margaret Ballin	- jez
ĺ	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Relies 8 Perse hell NO NO	Penne
	18. CAUSE OF DEATH Enter only one couse per line for (e). (b). end (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Conclusion Userular Conclusion	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which gover rise to immediate cause (a), stating the underlying DUE TO cause lest. (c)	5 yr
)	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PAI	RT 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
	206. ACCIDENT WAS UNDERLYING [] 206. DESCRISE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Part II of Iam 18.) OR CONTRIBUTING [] CAUSE OF DEATH OF LITHER, NOTIFY MEDICAL EXAMINER)	
	20¢. TIME OF INJURY Month, Dey, Year Hour a.m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20d. [Cily or town) (Complete the control of the control	ounty) (State)
	21. I certify that (ii) (this hospital) attended the deceased from 12/2/	
	220 SIGNATURE M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.	22b. DATE SIGNEL
	22c. PHYSICIAN'S NAME (Type) N' I + Forward MD M N ches + CT Md 22d ADDRESS NAME (Type) N' I + Forward MD M N ches + CT Md 23d RIPLAN COPMATION 123D DATE THEREOF 123c NAME OF CEMETERY OF COMMITTEE 123d, LOCATION [City, lown of country]	2/17/67
	REMOVAL (Specify) Burial Feb. 20, 1967 Fairfield Union Fairfield, Adams	Co. Pa
[4] 52	Clarence E. Wilson Emmitsburg, Md. dat FEB 2 1 1967 Milan	A 13



1	MARYLAND STATE DEPARTMENT OF HEALTH Mylsion of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	02072 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02067
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
	a. COUNTY Carroll MARYLAND Laryland Carroll
Ssary, 5 may be 5 may be Department	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
may fur	Woodbine Life Woodbine
Depa after	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
Les Saary Ind 3 to the Fage 5 may be State Department hours after death	3. NAME OF First Middle (*) Last 4. DATE Month Day Yeer
y de and A3.	DECESED
ges 1, 2, an farm PM3.	5. SEX 1.6 COLOR OR BACE 17 MARQUES 1 NOTES MARQUES 18 PARE OF BIRTH 19. AGE (In years IF UNDER 1 YEAR HE UNDER 24 HRS.
th. The sees	Male White WIOOWEO OIVORCED Sept. 29, 1891 75 yrs. Hours Min.
er dea iive Pa with 1 and event	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY?
fter Giv gr w gr v s 1 s	Laborer Carroll Co., Md. U.S.A.
ours afte n 18. Gi e along pages 1 in any	13. FATHER'S NAME
24 hour litem of the part of t	George W. Rippeon Mary Catherin e Foreman 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
	(Yes, no, or unknown) (tryes give war or dates of service) 227-22-1319 Manley Reid Rippeon Same As #2
within pencil in miner's permit.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
ed win point warming the point	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CON CONCENTS THE CAUSE (a) CONSET AND BEATH LIMINEDIATE CAUSE (a) CONCENTS THE CO
ild be executed "pending" in "pending" in "it Medical Exan standard as burial-transit i cremation, or i	4201 DUE TO
e ex endic edica rial-t	Conditions, if eny, which agave rise to immediate (b)
uld b d "p ef Me a bui	cause (a), stating the DUE TO
ate shoule word he Chie	underlying cause last.) (c)
icate the the used to bu	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 19. WAS AUTO-17 PER FORMED? YES NO 202. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CAUSE OF DEATH. 204. CAUSE OF DEATH.
intiffe d to d to be u	20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.)
R: This cer ate, writin forwarded 3 should t	
te, Thi orwa orwa sho gent	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Society, Street, office bldg., etc.) Hour a.m. While Not While at work at work at work at work at work at work.
be fed a	p.m. 19 at work at work
CAMI cert uld uld s. s.	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection X, Inquiry, and in my opinion death resulted from: Natural causes X Accident Suicide, Homicide, Undetermined manner
AMINEF AMINEF The certificates the should be refiles. CTOR: Page designated a	death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner
4 4 8	ACTUAL SIGNATURE Desche SM.D. ASSISTANT MEDICAL EXAMINER [22. DATE SIGNED
Execute Page of for your NAL DIRECTOR IN THE PAGE OF T	DEPUTY MEDICAL EXAMINER DEPUTY DEPU
DEPUTY Melease exector. Princector. Petained for Funeral. Funeral.	NAME (Type) / W. Giern Sycient Address (Staget, And June Ovince County Vincing)
O DEPUTY M please exec director. Pea retained for o FUNERAL I of Health ou	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF TRANSPORT CHARACTERY OF COUNTY) REMOVAL (Specify) 2/07/1967 Carroll Co. 13
. 12-2-2	24. FUNERAL DIRECTOR ADDRESS 252. REC'D BY REGISTRAR'S SIGNATURE
VR AISME	C. II. Jaltz Box 141 Sylesville, 11d. DATE FEB 28 1967 Icharles Juste
3500 4-64	

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02073 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death by the funeral USUAL RESIDENCE (Where deceased fixed, if institution: Residence before admission) PLACE OF DEATH o. COUNTY a STATE b. COUNTY Carroll Carroll ve Carban, papers. Pages 1 event, within 72 haurs after MARYLAND b (ITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn)
FINKS DURG c. LENGTH OF STAY IN 16 c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? completely filled in R.D. 1 R.D. 1 YES 🗌 NO IX 3 NAME OF Middle Last 4. DATE Month Day Year First DECEASED Roberts Anita 26, A. Feb. 67 DEATH 19 (Type or print) 9. AGE (In years IF JNDER 1 YEAR IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7 MARRIED 「孙 **NEVER MARRIED** 8 DATE OF BIRTH remolve last birthdoy) Months Hours signed by the attending physician and co burial-transit permit. Then please remol burial, crematian, or remaval, and in any Female White May WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10a JSJAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWITE COUNTRY? INDUSTRY Co. Carroll Md. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Elizabeth Miller Henry Lessner IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates at service) 212-05-7388B H. Roberts Finksburg. John Md. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per hine for (a), (b), and (c), ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a by the haspital ar attending physician DHE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause be detached far use as the State Dept. of Health priar ta has been 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO J TO FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Not While at work 21. I certify that (1) (this mospital) attended the deceased from July 1965, to director, page 3 shauld should be filed with the 19 67, and that death occurred at A M, from causes and on the date stated above saw the deceased alive on 225. DATE SIGNED 220 SIGNATURE **ATTENDING** MED. DIRECTOR STAFF M.D. PHYS PHYS. 22d. ADDRESS PHYSICIAN'S NAME (Type) Clubalance 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23a BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) (State) Buria (Specify) /67 Immuneal Cemeterv Manchester Md Carroll 25b. REGISTRAR'S SIGNATUR 24. FUNERAL DIRECTOR 25g. REC'D BY REGISTRAR 1967 20 M 1/66 Tipton - Eline Funeral Home Hampstead, Md.

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH n and completely filled in by the funeral s remove carbon papers. Pages 1 and 2 in any event, within 72 hours after death. hours after death. PLACE OF DEATH a. COUNTY USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? LA YES NO executed within NAME OF First Middle DATE Month Day DECEASED FEB LESLIKE 1967 (Type or print) LIN TON OBERTSON DEATH 10 6. COLOR OR RACE DATE OF BIRTH AGE (In years | FUNDER 1 YEAR | FUNDER 24 HRS last birthday) | Months | Days | Hours | Min. 7. MARRIED [NEVER MARRIED DIVORCED [10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT lease and ir during most of working life, even if retired) INDUSTRY COUNTRY? KETIK certificate MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address death (Yes. no. or unkown) (If yes nive war or dates of service) CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TYCCARDIAN. the hospital or attending physician. DUE TO been so burit RTERIOSCUERCSIS Conditions, if any, which (b) gave rise to immediate **DUE TO** cause (a), stating underlying cause last. 38 (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Hemith p PERFORMED? YEARS MELLITUS NO [YES ! 20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) ö MEDICAL TIME OF INJURY Month, Day, Year 20f. (City or town) (County) (State) 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, I factory, street, office bldg., etc.) 0 Hour a.m. Not While After at work at work be retained 1963, to FEB. 10, 1967, that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased from. JAN. FUNERAL DIRECTOR: irector, page 3 slicini FEB.10 1967, and that death occurred at 730 AM, from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED page filld ATTENDING PHYS. MED. DIRECTOR M.D. Page 4 may 1 PHYS. 22d. ADDRESS PHYSICIAN'S director, p NAME (Type) WESTMINSTEP, MD. BURIAL, CREMATION, 23b. DATE THEREO! OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOYAL (Specify) FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 24. Melineter 1967 VR A15 (4) 15M 4-64



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02075 CERTIFICATE OF DEATH death law requires that the death certificate be executed within 24 hours after death. by the attending physician and campletely filled in by the funeral ransit permit. Then please pethave carbon papers Pages I and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll Maryland Baltimore County
c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) any event, within 72 hours after MARYLAND b. CITY OR TOWN (If autside carparate limits, C. LENGTH DE STAY IN 16 write RURAL and give nearest town) Sykesville 22vrs.7mos.12dvs. Sparrows Point d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) d. STREET ADDRESS IS RESIDENC ON A FARM? 2916 Salisbury Ave. Springfield State Hospital NO TY YES 🗌 3. NAME OF First Middle Lost 4 DATE Month Dov Year DECEASED OF ERNEST WILHO HOSE FEBRUARY 19 67 (Type or print) DEATH S SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years 62 vis Months Hours Days Male White 1-11:-05 WIDOWED DIVORCED IDo USUAL OCCUPATION (Give kind of work done IDB KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? and Machinist Pennsylvania
14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar removal, Axel Rose (last name unk. Rosa IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, ng. ar unknown) (If yes give war ar dates af service) 16. SOCIAL SECURITY NO. 17 INFORMANT 167-03-2781 Records, Springfield State Hospital crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-transit p PART). DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) Acute peritonitis Day Page 4 may be retained by the hospital or attending physician. DUE TO burial, Conditions, if ony, which gove (b) Perforated duodenal ulcer Davs nse to immediate cause (a). Months & DUE TO as been as the priar tal stating the underlying couse Gangrene of right leg due to arteriosclerosis Years last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
CBS with CNS syphilis, meningoencephalitic, with psychotic reaction 19. WAS AUTOPSY PERFORMED? this certificate has YES 😿 NO ٥ 200 ACCIDENT WAS UNDERLYING [205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH shauld be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home form. (City or town) (County) (State) Haur a.m factory, street, office bldg., etc.) Not While State | ot work O FUNERAL DIRECTOR: After at wark 2]. I certify that (I) (this haspital) attended the deceased fram , 19___, that (1) (we) last 2-9-67 M. fram causes and an the date stated above. saw the deceased alive an and that death accurred at 22a SIGNATURE 22b. DATE SIGNED ATTENDING 2-9-67 DIRECTOR directar, page 3 shauld b≡ filed v M.D. 22d ADDRESS Springfield State Hospital 22c. PHYSICIAN S Octavio A. Ruiz, M. D. NAME (Type) Sykasyille Maryland 23c NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) emeter 25b REGISTRAR'S SIGNATURE FUNERAL DIRECTOR **ADDRESS** 25g... REC'D, BY REGISTRAR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



1 (1			PARTMENT OF HEALTH W. PRESTON STREET, BALTIMORE, MAR	YLAND 21201			
1.2	02076	CERTIFICATE		02071			
Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the hospital or attending physician. Page 6 may be retained by the hospital or attending physician. Page 7 may be retained by the hospital or attending physician. Page 8 may be retained by the hospital or attending physician ond completely filled in by the funeral director, page 3 should be detached for use os the buriol-transit primit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremotitation of emovol, and in any event, within 72 hours after death.	PLACE OF DEATH a. COUNTY Carroll	MARYLAND c LENGTH OF STAY IN 16	Mar VLand	Carroll			
by the Page ours a	b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) WESTMINSTER	2 weeks	c CITY OR TOWN (If outs de carparate limits, write F	(UKAL and give nearest fawn) ,			
papers. papers. nin 72 h	d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, gi Carroll County Ceneral	ve street address) . Hospital	d STREET ADDRESS Niner Rd.	B IS RESIDENCE ON A FARM? YES X NO			
nt, with		Middle Charles Ro	SS OF DEATH	2 23 1967			
s. M	Tale White WIDOWED	DIVORCED O	ct. 4, 1893 9 AGE (In years 73 ast birthday) yrs	Manths Days Haurs Min			
ond in c	the Car Conductor Bal	D OF BUSINESS OR USTRY DO. Transit	It BIRTHPLACE (County & State, or foreign country) Balt ore Co., Md.	12. CITIZEN OF WHAT COUNTRY?			
movol, and ir	FATHER'S NAME John B. Ross		Marguerite Burns				
15	S WAS DECEASED EVER IN L.S. ARMED FORCES? 16 So (es, na, ar unknawn) (If yes give war ar dates of service) NO	-12-08/1 Mr		iner Rd., Md.			
sured by the grading buriol, cremotidar of the grading of the grad	18. CAUSE OF DEATH (Enter only one cause per line for (PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	a), (b), and (c)) PCULIATORY	I FAILURE	INTERVAL BETWEEN ONSET AND DEATH			
uriol, a	Canditians, if any, which gave (b) (b) AL	•	COTIC HEART DISE	HSE -			
or to b	stating the underlying cause last		DECOMPENSATED	WEEKS			
ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO	c PNEUMCI	VIIA	19 WAS AUTOPSY PERFORMED? YES NO			
L CERTIFICATION		RIBE HOW INJURY OCCURRED (I	Enter nature of injury in Part I ar Part II of item 18.)				
MEDICAL	20c TIME OF INJURY Manth, Day, Year Haur a.m. While p.m. 19	URY OCCURRED 20e PLACI Nat While facta	E OF INJURY (Hame, farm, Iry, street, affice bidg, etc.)	(Caunity) (State)			
the Sto	21. I certify that (1) (this haspital) attended the deceased fram 3/8, 1967, ta 3/23, 1967, that (1) (we) last saw the deceased alive an 3/33 1967, and that death accurred at 1/38 M, fram causes and an the date stated abave.						
d with	Where A. fre	Ew of M.D	ATTENDING MED STAFF	226 DATE SIGNED			
IO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the buriol-transhould be filed with the State Dept. of Health prior to buriol, creases the contract of the state of	22c PHYSICIAN'S NAME (Type)	0	22d. ADDRESS				
should	da BURIA., (REMATION, REMOVAL (Specify) 2/25/67	23c NAME OF CEMETERY OR C	REMATORY 23d. LOCATION (City or 1 em. Gardens Finksbur	Idwn) (Caunty) (State)			
A15 (4) 2	4. FUNERAL DIRECTOR H.J. Echlardt Owings Mi	ADDRESS	2Sa. REC'D BY REGISTRAR 2Sb.	REGISTRAR'S SIGNATURE			



IN		MARYLAND STATE DEPARTMENT OF HEALTH A RIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	ARVI AND
i and		02077 CERTIFICATE OF DEATH 020	72
funeral funeral death.	1.	PLACE OF DEATH a. COUNTY D. STATE D. COUNTY D. COUN	idence before admission)
after the figure 1 after after after	_	CATTOUT MARYLAND MARYLAND CA	rrell
s af by t	Ι,	b. CITY OR TOWN (If outside corporate limits, write RURAL at write RURAL and give nearest town)	nd give nearest town)
hour d in rs. hou	<u> </u>	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS	A IS RESIDENCE
within 24 hours sletely filled in by arbon papers. Part, within 72 hours it, within 72 hours	_	Route 97 Route 97	0. IS RESIDENCE ON A FARM? YES NO
	3.	OECEASED (Type or print) JAMES HARRIS SANNER SE DEATH Feb. 1	Day Year 0, 1967
be executed cian and com se remove c	5,	SEX G. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 189) S. AGE (In years If UNDER 1	YEAR IFUNDER 24 HRS.
and remo	10	TIFE CONTROL WIDOWED DIVORCED 10/4 /9 //7/15/ 12 vrs.	
ath certificate be attending physician rmit. Then please in, or removal, and in	qui	ing most of working life, even if retired) INDUSTRY	IZEN OF WHAT INTRY?
ate ple ple al, al	13		S, A .
rtific ing p Then	1	Seorge R. SAMPER LAURA MACKEY	
h ce tendi it.	15 (Y	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT Address	4.1
deatl e at perm ion,		No MR. HATTIS SAMMER, JR Woodbin	
the yy the sait		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),] PART I. DEATH WAS CAUSED BY:	ONSET AND DEATH
hat ician led 8 -trai		IMMEDIATE CAUSE (a) INTERCUTION OF COTONARY AFTERY	few min.
es t ohysi sign uria wria		Conditions, If any, which \ (b) Chronic Hypertensive Cardiovascular	
ing ling ling ling line b		gave rise to Immediate Course (a), stating the DUE TO Disease	15+ yrs.
aw r tend tas t as t prior	Z	underlying cause last.) (c)	119. WAS AUTOPSY
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending phys director, page 3 should be detached for use as the burial-transit permit. Then pies should be filed with the State Dept. of Health prior to burial, cremation, or removal, and the state Dept.	CERTIFICATION	PARTITION HER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PARTITIES	PERFORMED?
CIAN: spital certifi led fo	SERTIF	20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CO	
HYSI he ho this etack Dep		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (Count	ty) (State)
by the tate	MEDICAL	Hour a.m. While Not While p.m. 19 at work at work	
D HOSPITAL OR ATTENDING Page 4 may be retained by FUGRAL DIRECTOR: After director, page 3 should be should be filed with the State			_, that (I) (we) last
ATTE retail CTO sho		saw the deceased alive on 10/Feb/67 19 , and that death occurred at 1 P M, from the causes and on the	e date stated above.
OR be Jike 3 ge 3 ed w		M.D. ATTENDING MED. STAFF DIRECTOR PHYS.	2 5101125
ITAL may RAL r, pa		22c. PHYSICIAN'S NAME (Type)	
IDSP ge 4 UNE CCO	_	Um. H. Lawson, Jr., M.D. Box 54 RD #2, Sykesville, No.	
Pa P	23:	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or cound removal (Specify) 2-13-67 WARDS CAFEL COMERCY SAFELY.	(State)
200	24	Alan All Ylain I I I I I I I I I I I I I I I I I I I	SIGNATURE
VR AI5 (4) 1/9	1	Harry W. Haight sycloside, Mr. DATEFEB 16 1967 Journe	yudge

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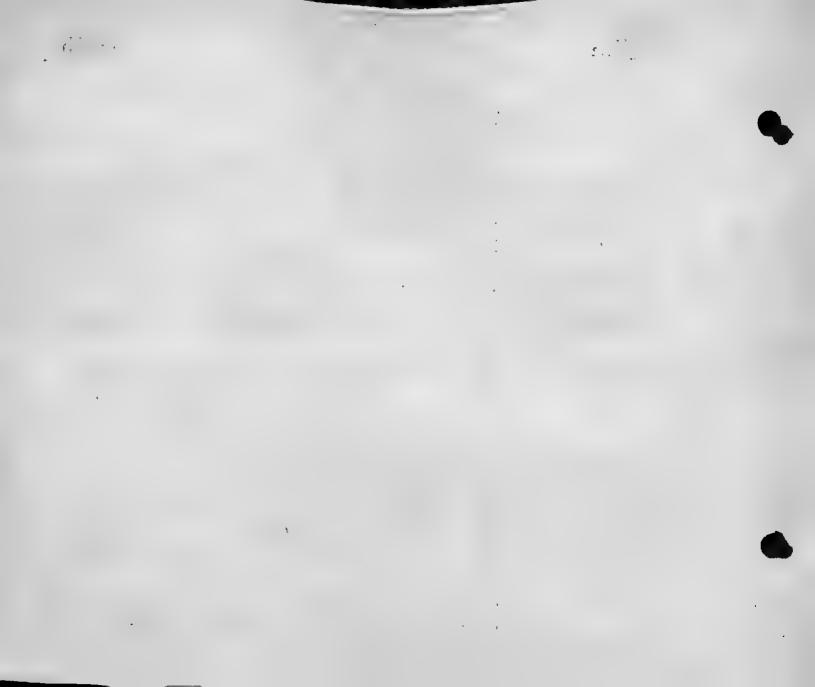


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02078 CERTIFICATE OF DEATH certificate be executed within 24 hours after death. Sician and completely filled in by the funeral please remove carbon papers. Pages 1 and 2 1, and in any event, within 72 hours ofter death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. SIME Baltimore County Carroll MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (f autside corporate limits c. LENGTH OF STAY IN 16 write RURAL and give necrest town)
Sykesville Randallstown Limos. 13dvs. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Springfield State Hospital 3808 Courtleigh Drive NO T YES 🗔 3 NAME OF First Middle 4. DATE Doy Last Month Year DECEASED (Type or pnot) AUGUST TOHN SCHMTTT DEATH 19 67 FEBRUARY IF UNDER I YEAR S SEX JE UNDER 24 HRS 6. COLOR OR RACE 9. AGE (In years 7. MARRIED NEVER MARRIED DATE OF BIRTH birthday) Manths Days Наитѕ 8-8-1897 Male White Sep DIVORCED 10a, USUAL OCCUPATION (Give xind of work dane KIND OF BUSINESS OR 10h. 11. BIRTHPLACE (County & State or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Fireman Keti to. ILS. Maryland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remova Frederick Schmitt Katherine Schmidt 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address low requires that the death the attend (Yes, no, or unknown) (If yes give wor or dotes of service permit. Yes - Army, 1916-1919 218-26-3625 Records, Springfield State Hospital buriol, cremation. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b) buriol-tronsit ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Poge 4 moy be retained by the haspitol or attending physician. signed ! DUE TO Canditians, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse os the prior to b this certificate has been Years WAS AUTOPSY Il OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YOU OTHER SIGNIFICANT CONDITIONS GIVEN IN PART 1(a) PERFORMED? USe without qualifying phrase NO K ō 20a. ACC DENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH 10 detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) be detoched Stote Dept. c 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, office bldg., etc.) Hour a.m While Not While After at wark at work 21. I certify that (I) (this hospital) attended the deceased from 9-23-66 19____, that (I) (we) last be filed with the and that death occurred at saw the deceased alive an2-6-67 O FUNERAL DIRECTOR: W. fram causes and on the date stated above. 220 SIGNAPURE 22b. DATE SIGNED 90 2-6-67 M.D. DIRECTOR PHYS 22d. ADDRESSpringfield State Hospital 22c. PHYSICIAN'S NAME (Type) H Sykesville. Maryland Connor director, should be 23d. LOCATION (City or Town) DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY BURIAL CREMATION. (County) (Stote) REMOVAL (Specify) emeter FUNERAL DIRECTOR ADDRESS 25o. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

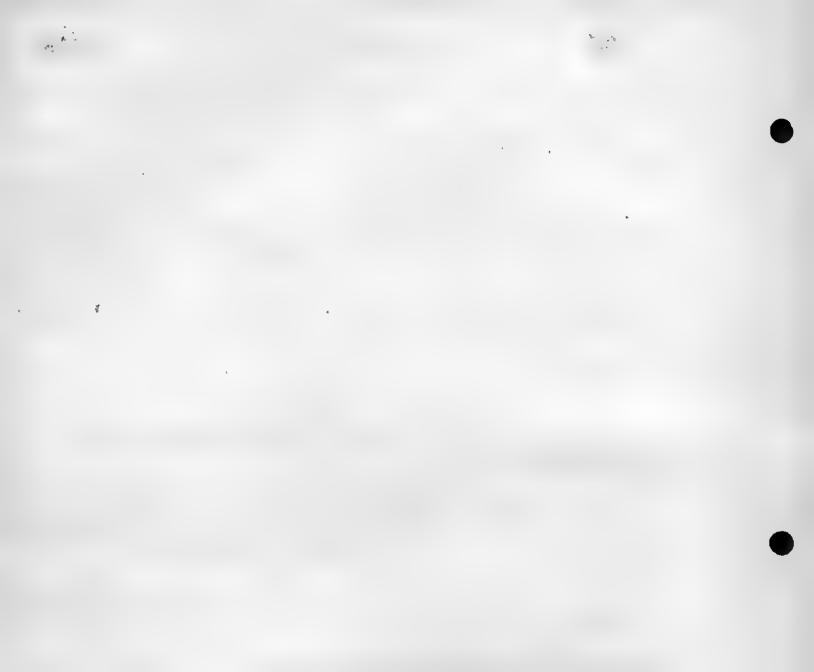


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02073 CERTIFICATE OF DEATH executed within 24 hours after death ly filled in by the funeral aan papers. Pages I and within 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o COUNTY o STATE Maryland Allegany Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) Cumberland 7mos 21dvs Sykesville d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 6 IS RESIDENCE ON A FARM? completely filled 16 N. Lee Street Springfield State Hospital NO X YES [corban 3 NAME OF Middle 4. DATE Month Doy Year DECEASED ANNE GERTRUDE SHERRED 67 FEBRUARY (Type or print) 19 DEATH 6 COLOR OR RACE X 8. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED signed by the oftending physicipal and computed buriol-tronsit permit. Then please selbove last birthdoy) Hours 10-12-1891 White DIVORCED Fema.1e 100 USUA, OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT The law requires that the death certificate be during most of working life even if retired) INDUSTRY COUNTRY? West Virginia Housewife U-S-A 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or remova John Ross Webb Elizabeth (last name unk.) TS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 214-05-5869A Records, Springfield State Hospital buriol, cremotion. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY CHSET AND DEATH Carcinoma of esophagus IMMEDIATE CAUSE (o) DUE TO Acute peritonitis due to superior mesenteric Conditions, if any, which gave 3 Davs rise to immediate couse (a), artery thrombosis use os the l stoting the underlying couse Page 4 moy be retained by the hospital or ottending After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CBS assoc. with sentile brain disease, without qualifying phrase YES X NO þ 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) detached 1 OR CONTRIBUTING CAUSE OF DEATH State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year (County) Hour o.m. foctory, street, office bldg., etc.) Not While 19 of work ot work 21 I certify that (I) (this haspital) attended the deceased fram 6-10-66 __ , that {I) {we} last 3 should I and that death accurred a 5:15 My fram causes and an the date stated above. TO FUNERAL DIRECTOR: saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED ATTENDING 2-7-67 director, page 3 should be filed w M.D. DIRECTOR 22d. ADDRESS Springfield State Hospital 22C. PHYSICIAN S NAME (Type) Agustin del Campé Sykesyille. Maruland 230 BURIAL CREMATION DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town (County) (Stote) REMOVAL (Specific) 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS





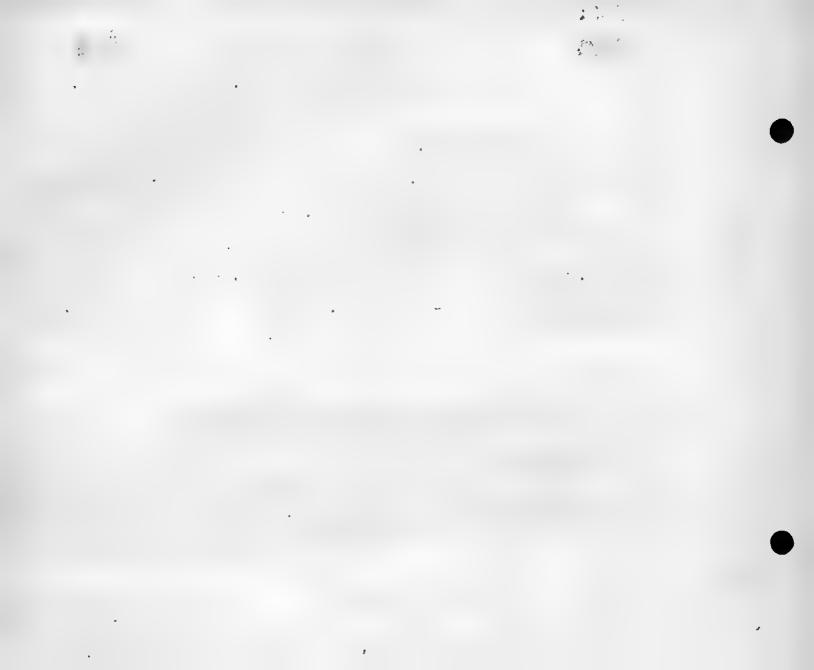
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02081 CERTIFICATE OF DEATH 2puo remuires that the death certificate be executed within 24 haurs after death physician and completely filled in by the funeral on please remove carbon papers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY Frederick Garroll Jarvland MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 write RURAL and give negrest town) Brunswick e IS RESIDENCE d STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM? Rosemont Carroll Co. General Hospital YES NO X 3 NAME OF First Middle 4 DATE Month Doy Year Lost DECEASED 2 1967 TATALTE SHAW (Type or print) DEATH s SEX 6 COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED - last birthdoy) Doys Hours WIDOWED TX DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, eyen if retired)
HOUSEWIIE COUNTRY? A. INDUSTRY Marvland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending phys cremation, or remova George Shaw Myra Forrest WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service 216-46-0521 Mrs. Murial Kable Westminkster I'd. no INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART I, DEATH WAS CAUSED BY. signed by the buriat-tronsit p RIGHT ARCINOMA OF IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove ISTANT METRISTASES VERRS rise to immediate couse (a), DUE TO ed for use os the l stating the underlying couse TO FUNERAL DIRECTOR: After this certificate hos been lost. WAS AUTOPS) PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) REBRAI YES 🗍 NO ASCULAR INSUFFICIENCY 20o. ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (State) 20c TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED (County) factory, street, office bldg., etc.) Not While at work 21. I certify that (I) (this hospital) attended the deceased from... . 1967, that (I) (we) lost 2/6 . 1967 to 1967, and that death accurred at 95% M, fram causes and an the date stated above. saw the deceased alive on 220.-SIGNATURE 226 DATESIGNED ATTENDING director, page 3 should be filed v M.D DIRECTOR 22d. ADDRESS 22E PHYSICIAN'S NAME (Type) 230. BURIAL (REMATION REMOVALISHED IN 230 NAME OF CEMETERY OF CREMATORY
Aount Olivet Cemetery 23d. LOCATION (City or Town) prunswick ld. 2So. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24 JUNERAL DIRECTOR VR A15 (4) DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY a. STATE npletely filled in by the f carbon papers. Pages 1, ent, within 72 hours after COUN MARYLAND b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) くけつに d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? No X YES NAME OF First Middle DATE Last 4. Month Day DECEASED event, (Type or print) WARE DEATH 19 6 5. SEX 6. COLOR OR RACE AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. гетпоче DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Days Hours any and WIDOWED DIVORCED Ξ 10a. USUAL OCCUPATION (Give kind of workdone | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT Sician lease r and in (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? 005Eh ON removal, ם 13. FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT BETHELRD 9 signed by the atta burial-transit permit burial, cremation, or (Yes, no, or unkown) (If yes give war or dates of service) 86B REV. KARL WAREHEIM NKSBURG-18. CAUSE OF OEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: attending physician. hs. IMMEDIATE CAUSE (a) has been signed as the burial-tr prior to burial, o **DUE TO** Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN INPART I(3) 19. WAS AUTOPSY for use Health PERFORMED? certificate CERTIFICATI NO YES [20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: DISCRIBE HOW MURY OCCURRED, (Enter nature of Injury in Part I or Part I of Marm 18. this certil detached for te Dept. of I 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY Home, farm, 20f. (City or town) (State) (County) factory, street, office bldg., etc.) Hour a.m. Not While After p.m. at work at work retained P 21. Legrify that (I) (this hespital) attended the deceased from 語 DIRECTOR: age 3 should led with the saw/the deceased alive on 2190 and that death occurred at M. from the causes and on the date stated above. SIGNATURE DATE SIGNED 22a. 8 8 ATTENDING DIRECTOR STOTATOS E I O HOSPITAL director, p 22c. ADDRESS 22d. NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 23c. REMOVAL (Specify) FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 57 196 VR A15 (4) DATE 20M 1/65

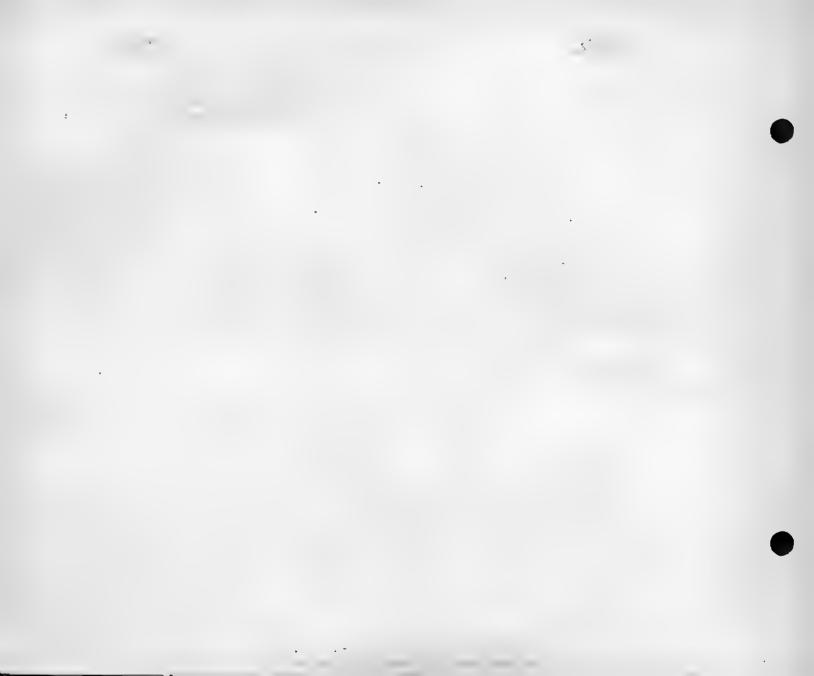


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02083 death. requires that the death certificate be executed within 24 hours after death and, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before odmission) a COUNTY a. STATE **b** COUNTY Carroll Balto. MARYLAND b CITY OR TOWN (If outside carparate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) Reisterstown d NAME OF HOSPITAL OR INSTITUTION (15 not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? and campletely filled in Carroll County General Hospt. Old Hanover Road YES NO X carban 3. NAME OF First Middle 4 DATE Day Last Month Year DECEASED Marion S. Welsh 2 18 196 (Type at pnnt) DEATH S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 反 remave birthday) Months Doys Hours Female White Sept. 22, 1895 WIDOWED DIVORCED 10a USUA, OCCUPATION (Give kind of work done 105 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12. CIT ZEN OF WHAT during most of work no life, even if retired) INDUSTRY COUNTRY? Balto. City 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or remova Edward E. Lewis Ella J. Rhoten WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address permit. (Yes, no, or unknown) [(If yes give war or dates of service) 220-48-5226 Reisterstown, Md. Mr. A. Earl Welsh No 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: VIAPHRAG MATIC IMMEDIATE CAUSE (a) signed by DUC TO VOCAPDIAL INFARCTION HOURS Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse TO HOSPITAL OR ATTENDING PRISOLULY. Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been to FUNERAL DIRECTOR: After this certificate has been to Funeral and the detached far use as the mist PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 19 WAS AUTOPSY PERFORMED? of Health NO F 20a ACC DENT WAS JNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m. factory, street, office bldg., etc.) Not While at wark , 1962, to. 21. I certify that (1) (this haspital) attended the deceased fram. 19____, that (I) (we) last , and that death accurred at 6 5 2/18 saw the deceased alive an M, fram causes and an the date stated above. 22ar2SJGNATURE 22b DATE SIGNED ATTENDING M.D. DIRECTOR 22d. ADDRESS 22c PHYSICAN S NAME (Type) director, should be 23d LOCATION (City or Town) 23g. BURIAL CREMATION. 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) REMOVAL (Specify) Finksburg, Md. Evergreen Memorial 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 25g. REC'D BY REGISTRAR VR A15 (4) J. F. Eline & Sons Reisterstown, Md. 20 M 1/66 cherre on



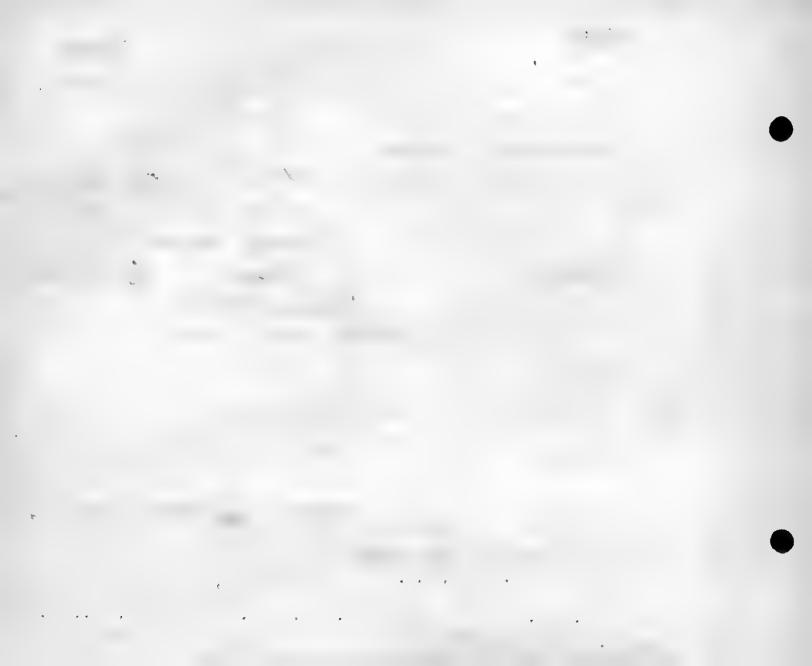
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02084 requires that the death certificate be executed within 24 hours after death the ottending prosition and completely filled in by the funeral sit permit. Their please remove corban papers. Pages, and narion, or removel, and in any event, within 72 hours offer deat 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) 1 PLACE OF DEATH a. COUNTY a STATE b. COUNTY MARY ANd -Baltemore CARRA MARYLAND b. (ITY OR TOWN (if ourside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 15 c CITY OR TOWN (If gotside carparate limits, write RURAL and give negrest town) BAlt: more 4Kesvi 25415, - 5moles d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS B IS RESIDENCE ON A FARM? YES. NO X 3 NAME OF 4. DATE DECEASED ÔF (Type or print) W: MMER 1967 DEATH 12 (1) A R S SEX 9. AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS A COLOR OR RACE 7 MARRIED X NEVER MARRIED 8 DATE OF BIRTH WIDOWED lost birthday) Davs Haurs 8-25-1884 DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a USUA, OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State or foreign country) during most of working life, even if retired) INDUSTRY **COUNTRY?** 71.S. A SalicitoR 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Eliz Abeth Edward M. W: MMER 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dates of service) 16. SOCIAL SECURITY NO -2819 GREEN EXTUN DR. 315-07-923 Records UNANCON INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per fine for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY burral-transit IMMEDIATE CAUSE (c) signed by DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO stating the underlying cause by the hospitol or attending os the TO FUNERAL DIRECTOR: After this certificate hos been 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) detached for use e Dept. of Health YES NO [20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) foctory, street, office bldg., etc.) Nat While at work 21. I certify that (I) (this hospital) attended the deceased fram 9 - 9, 1941, to 3 - 12, 1967, that (I) (we) last saw the deceased alive an 3 - 12, 1967, and that death occurred at 445. M, from causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. PHYS DIRECTOR director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S A JONCHERE MD NAME (Type) /2. 23a BURIAL CREMATION, REMOVAL (Specify) 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) WARK CEMETERY 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Eltsworth, Armacost-4600 Liberty Hights. Ave. DATE EB Ullayeren

MARYLAND STATE DEPARTMENT OF HEALTH

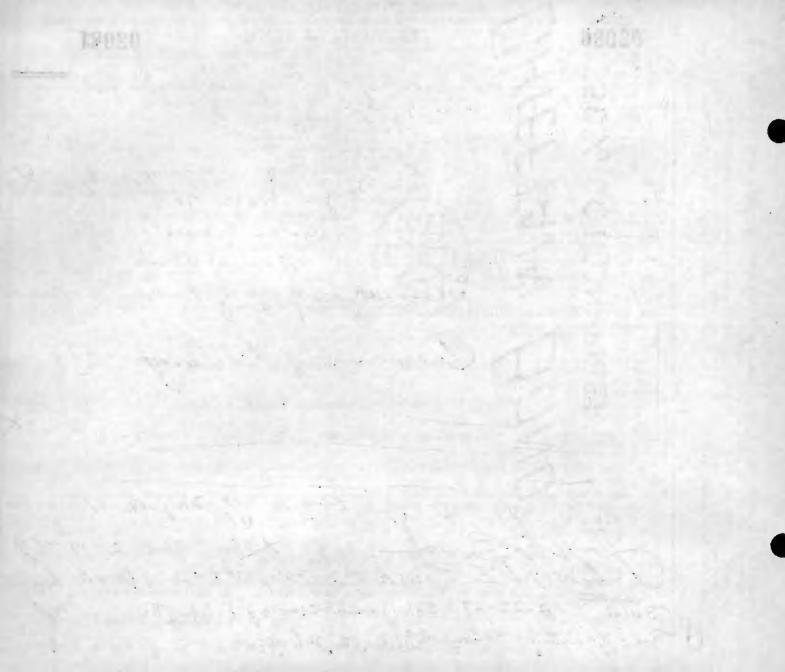


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02085 CERTIFICATE OF DEATH and 2 death. requims that the death certificate be executed within 24 hours after death completely filled in by the funeral tope carbon papers. Pages 1 and PLACE OF DEATH-2. USUAL RESIDENCE (Where deceosed lived, if institut on Residence before admission) a. COUNTY o. STATE **b.** COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits. c LENGTH OF STAY IN 16 outside carparate firmits, write RURAL and give nearest town papers Page hin 72 haurs o write RURAL and give nearest town) PONETON OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ON A FARM? YES NO D 3. NAME OF Midd e Month Doy Year DECEASED 196/ (Type or print) DEATH IF UNDER 1 YEAR If UNDER 24 HRS. S. SEX AGE (In years 6. COLOR OR RACE n any eva X lost birthdoy) Months Days Hours WIDOWED DIVORCED the attending physician and sit permit Then please rem 100 USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired INDUSTRY **COUNTRY?** 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal. 1 Sood Ward WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMAN 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates of service) 0 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO storing the underlying couse 10 FUNERAL DIRECTOR: After this certificate has been the lost. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO X YES [far 200 ACCIDENT WAS UNDERLYING [1] 205, DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED Hour am foctory, street, office bldg, etc.) Not While of work L of work 21. I certify that (I) (this haspital) attended the deceased from 2 - 24 1967 to 81 19<u>6</u> / that (1) (vi) last Page 4 may be retained I 70 2-27 19 67, and that death accurred at 900 M, from causes and on the date stated above. saw the deceased alive and 22o. SIGNATURE 22b DATE SIGNED MED DIRECTOR 2-27-66 PHYS 22d ADDRESS 22c PHYSICIAN'S Karl M. Green, M.D. Westminster, Maryland NAME (Type) directar, 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL CREMATION 23b. DATE THEREOF 23d LOCATION (City or Town) (County) Westminster, Car., Carroll Co. Hosp. 2-27-67 Carroll Co. Gen. Hosp. 2So. REC'D BY REGISTRAR 2Sb Glenn R. Fisher, Administrator Carroll County General Hospital 1967 VR A15 (4) 20 M 1/66 DATE

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. CDUNTY a. STATE b. COUNTY after MARYLAND b. CITY DR TDWN (if outside corporate limits. C. LENGTH DF STAY IN 1b c. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) Pag write RURAL and give nearest town) ve carbon papers. Pag event, within 72 hours 128 Nmani .5 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street andress) e. IS RESIDENCE d. STREET ADDRESS DN A FARM? YES PND within completely NAME OF Middle DATE Last Month Day DECEASED E (Type or print) DEATH 19 BHUDLY AGE (In years of UNDER TYEAR IF UNDER 24 HRS. last pirthday) Months | Days | Hours | Min. етоме SEX 6. CDLDR DR RACE DATE OF BIRTH NEVER MARRIED 7. MARRIED and DIVDRCED WIDDWED 10a. USUAL DCCUPATION (Give kind of work done) 12. CITIZEN DF WHAT 10b. KIND DF BUSINESS DR (County & State, or foreign country) physician certificate be during most of working life, even if retired) INDUSTRY CDUNTRY? 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME remova 15. WAS DECEASED EVER IN U.S. ANMED FORCES? INFORMANT VE. SDCIAL SECURITY ND. Address 17. permit. death (Yes, no, or unkown) | (If yes give war or dates of service) cremation, the INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] that the been signed of the burial-transit or to burial, crem DNSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a) DUE TD The law requires Cenditions, If any, which gave rise to Immediate as the prior to DUE TO cause (a), stating the underlying cause last. WAS AUTDPSY PART HI. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. for use Health PERFORMED? certificate hospital or ND 🔯 YES ATTENDING PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING F DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) hed f DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER) detach (State) 2Dc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE DF INJURY (Home, farm, 2Df. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While After p.m. at work at work retained Februar 21. I certify that (I) (this hospital) attended the deceased from. DIRECTOR age 3 sho led with t and that death occurred at 11 PM, from the causes and on the date stated above. saw the deceased alive on 2 22a. SIGNATURE 22b. DATE SIGNED be 9 ATTENDING filed M.D. PHYS. DIRECTOR TO HOSPITAL Page 4 may FUNERAL PHYSICIANS 22d. director, p ADDRESS NAME (Mpe) BURIAL, GREMATION. DATE THEREDS 23d. LDCATION (City, town or county) (State) 23h. 23c. 01 REMOVAL (Specify) SAndymount Cemeler FUNERAL DIRECTOR REC'D BY REGISTRAR V REGISTRAR'S SIGNATURE VR A15 (4) 1/65



	1	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
		02087 CERTIFICAT	TE OF DEATH	02082			
)		PLACE OF DEATHY O. COUNTY OFFO	Q. STATE	deceased lived, if institution: Residence before admissions b. COUNTY			
/	-	b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside	carparate limits, write RURAL and give nearest tawn)			
		write RURAL and give nearest town	Westm	instac 06.1			
60		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General	d. STREET ADDRESS Gre	en wood Ave e. IS RESIDENCE ON A FARM? YES NO]			
		NAME OF First Middle DECEASED (Type or print) DENSE MARIA	フェナ	DATE Manth Day Year OF 2 - / 1967			
	S.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH 12-8-66	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthday) Months Days Haurs Min. yrs. 2 3			
		. USUAL OCCUPATION (Give kind of work dane ing mast of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Sto				
	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
		Vimmy Zen72	Dorothy	LenTz			
	15.	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 17. 18. na, ar unknawn) (If yes give war ar dates af service)	INFORMANT /	Address ZENTZ			
Should be lifed will file State Dept. or nealin prior to borror, tremaining or remova		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Dack Jaie	INTERVAL BETWEEN ONSEL AND DEATH			
		DUE TO TO	1. tin	7 7-16.			
		Conditions, if any, which gave (b) (b)	was J	· a will			
		last. DUE TO					
1	TION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	O THE TERMINAL DISEASE CONDITION	IN GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO NO NO NO NO NO NO N			
	CERTIFICATION	200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. Pl	LACE OF INJURY (Hame, form, actory, street, affice bldg., etc.)	20f. (City ar tawn) (Caunty) (State)			
		21. I certify that (I) (this haspital) attended the deceased from_	1-31,197				
			hat death occurred at/	A M, from causes and on the date stated above.			
		7-00-11		CTOR STAFF 22b. DATE SIGNED			
3		22c. PHYSICIAN'S NAME (Type) KARLL M. GREEN	122d. ADDRESS INESTMI	NSTER MD			
1	-		D CDCHATODY	23d. LOCATION (City or Town) (County) (State)			
1	230	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY O	IK CKEMATORY	LECTED (ALETED 44)			
	1	BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF CEMET	TER CEMETRY 250. REC'D BY	WESTMINSTER, MD.			

6-193141

18020 SPASA STATE OF THE PARTY Live of Land Walnut and the same will have MARIA ZOUTE They want The second secon White I have been a fine PARIS A TREEN MESTRINSTER AD THE STEP WESTERN STREET, STREET, THE STREET, ST. The state of the s